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Therapists' conceptualizations of the function and meaning of "delicate self-cutting" in female adolescent outpatients.

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THERAPISTS' CONCEPTUALIZATIONS OF THE FUNCTION AND MEANING OF "DELICATE SELF-CUTTING" IN FEMALE ADOLESCENT OUTPATIENTS

A Dissertation Presented

by

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ABSTRACT

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The "delicate self-cutting syndrome" (Pao, 1969) refers to repetitious non-lethal cutting or scratching traditionally associated with female adolescents. While research and theory have explained the reasons for this behavior in various ways, little attempt has been made to integrate these reasons into broader models. An examination of the literature suggested eight clearly differentiable models that integrated groups of reasons: behavioral, systemic, avoidance of suicide, sexual, expression of affect, control of affect, ending depersonalization and creating boundaries. This study evaluated these models and investigated the relationships between them by surveying therapists about the conceptualizations they use to understand patients who engage in delicate self-cutting. Related developmental issues were also briefly investigated. A pretest was conducted with clinical psychology graduate students and faculty to validate the theoretical associations between specific reasons and the models used to integrate them. The main survey asked a nationwide sample of psychologists and social workers who treat adolescents and adults in individual outpatient therapy to rate a patient on the

specific reasons for cutting and the integrative models. Forty-four completed surveys were analyzed. The systemic, suicide, sexual, expression, depersonalization and boundaries models were supported by a factor analysis and the generation of alpha coefficients. Examination of the patterns of relationships between and within models and individual reasons suggested that the behavior model was undifferentiable from the systems model and that the control model addressed the general need to regulate affect and was an issue underlying all other models. The expression model showed a similar patterns of relationships while maintaining its ability to be differentiated. A new structure is hypothesized with control and expression models reflecting basic underlying functions of the self-cutting behavior and the other six models reflecting more subjective meaning assignment. Results also indicated that therapists find the expression, control, depersonalization and boundaries models most useful in understanding and treating their patients. There was little support for the sexual or suicide models. Implications for therapeutic interventions and difficulties are examined in light of the new structure and therapists' preferences for certain models. Directions for future research are proposed.

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CHAPTER I

INTRODUCTION

Pathological self-mutilating behavior has been clinically examined for over 65 years (Doctors, 1991). Research has generally indicated that self-mutilation is more prevalent than one might think (Favazza & Conterio 1988). Case studies, clinical observations, and research have contributed to describing and understanding the presentation and common characteristics of patients who self-mutilate. In addition, while the possible underlying dynamics or reasons behind the self-destructive behavior have been discussed, there is little agreement on these dynamics or reasons. Walsh and Rosen (1988) state: "one could say that the field has manifested diversity regarding interpretations of the meaning of self-mutilating acts but considerable unanimity regarding the antecedents of these acts" (p. 182). Ettinger's (1992) interviews focusing on the self-reported function and meaning indicated that the experiences that helped self-mutilators feel better and decrease or stop self-mutilating were (a) being in therapy, (b) talking with others with similar experiences, and (c) gaining a better understanding of the meaning and function of self-injury. These results suggest that understanding the intent and meaning of the behavior could be quite important for therapists who are attempting to help these patients.

Definition

Self-mutilation may be broadly defined as any behavior intentionally producing injury to one's own body, regardless of one's

current rationale (Gustafson, 1991; Simpson, 1980). This broad definition encompasses behaviors that are traditionally differentiated from pathological self-mutilation, such as ear piercing or tattooing (Favazza, 1989; Simpson, 1980; Walsh & Rosen, 1988). This definition also does not differentiate self-mutilation from the self-injurious behavior seen in mentally retarded or autistic children, which many authors see as different in intent, underlying dynamics and associated developmental and psychological experiences (Favazza, 1989; Feldman, 1988; Johnson & Rea, 1986). Many authors advocate that the definition of pathological self-mutilation should take into account degree of damage, directness, number of episodes, social acceptability, and intent or psychological state (Favazza, 1989; Kahan & Pattison, 1984; Pattison & Kahan, 1983; Simpson, 1980; Walsh & Rosen, 1988).

Favazza (1989) differentiates between major self-mutilation--such as eye enucleation or self-castration--and moderate self-mutilation--such as skin cutting or burning. The reasons behind these may be quite different as the former is usually associated with severe psychological disorders such as mania, depression, schizophrenia and organic mental disorders while the latter is associated with a variety of other psychological conditions (Favazza, 1989; Simpson, 1980). Many authors also advocate that self-mutilation should be differentiated from suicide. While some authors have demonstrated a relationship between self-mutilation and suicidal ideation (Lee, 1987, Lester & Gatto, 1989; Schwartz, Cohen, Hoffman & Meeks, 1989), most authors agree that self-mutilation can be clearly differentiated from suicidal acts and

gestures in terms of the patient's perception of the event, the proposed function of the behavior and the associated features (Doctors, 1981; Feldman, 1988; Firestone & Seiden, 1990; Graff & Mallin, 1967; Grunebaum & Klerman, 1967; Gustafson, 1991; Lee, 1987; Pao, 1969; Rosen, Walsh & Rode, 1990; Schwartz et al., 1989; Simpson, 1980).

Perhaps the definition that would best fit the majority of studies on self-mutilation is that self-mutilation is a direct, socially unacceptable behavior that causes physical injury where the individual is not attempting suicide but is in a psychologically disturbed state.

Prevalence

Favazza and Conterio (1988) estimate the incidence of self-mutilation to be 750 per 100,000, or 1800 per 100,000 in persons aged 15 to 35. This estimate is likely an underestimate of the actual incidence as it is based solely on the prevalence of the disorders in the DSM-III that list self-mutilation as a symptom behavior. A higher incidence is supported by studies such as that of Whitehead (cited in Simpson, 1980) which estimated an incidence of 730 per 100,000 self-mutilating incidents *annually*, based on information provided by physicians; many of these cases were not hospitalized and 60% had a history of previous self-injury, although the physicians were aware of only 20% of the previous self-injurious episodes. Even this may be an underestimate; Simpson states:

> Many cases of self-mutilation are not reported or recorded at all. The wounds are often easily cared for by

> the patient without help, or may be treated by doctors as accidental, nonintentional, simple lacerations. The true incidence is certainly underestimated in the studies cited so far. (Simpson, 1980, p. 259)

Walsh and Rosen review available incidence data, commenting that the incidence of self-mutilation has markedly increased since the 1960's. They reflect that determining the incidence of this behavior is difficult not only due to underreporting but also because many studies are either overinclusive--including suicidal acts and different types of self-harm such as poisoning, or underinclusive--including only one type of self-mutilation such as cutting or burning. They conclude that the range in incidence is somewhere between 14 and 600 per 100,000 persons annually. Ettinger (1992) calculated that, given the current United States population estimate of 240 million, this means between 33,600 and 1,440,000 people engage in self-injury.

The incidence of self-mutilation in the psychiatric population is much higher than in the general population, ranging from 4.3% to 20% of all psychiatric inpatients (Darche, 1990; Doctors, 1981). If the population evaluated is limited to adolescent inpatients, the incidence rate rises dramatically, approaching 40% (Darche, 1990).

Associated Diagnoses

Favazza (1989) states that self-mutilation is mentioned explicitly in five DSM III-R diagnoses: borderline personality disorder, multiple personality disorder, sexual masochism, trichotillomania and factitious disorder with physical symptoms. Traditionally, self-mutilation is most associated with a diagnosis of

borderline personality disorder (Favazza & Conterio, 1988; Gardner & Cowdry, 1985; Kernberg, 1988; Leibenluft, Gardner & Cowdry, 1987; Offer & Barglow, 1960; Walsh & Rosen, 1988), but other diagnoses such as major depression, minor depression, obsessive-compulsive disorder, alcoholism, eating disorders, schizophrenia and anxiety disorders (Brittlebank, Cole, Hassanyeh, Kenny, Simpson & Scott, 1990; Offer & Barglow, 1960; Darche, 1990) have been associated with self-mutilation.

It may be quite difficult to accurately diagnosis a patient whose primary presenting symptom is self-mutilation. These patients may fulfill some of the criteria for a specific diagnosis but may be markedly different from other criteria (Darche, 1990; Kahan & Pattison, 1984; Simpson, 1980) Darche (1990) concludes: "...self-mutilating patients--with their variety of symptoms and the lack of consensus about the motivation behind their behavior--do not fit into the DSM III-R categories as well as other patients" (p. 34). The difficulty assigning an accurate diagnosis is further complicated by the possibility that, because of the strong traditional association between borderline personality disorder and self-mutilation, there may be a bias towards diagnosing borderline personality disorder. Indeed, Simpson concludes: "The choice of diagnosis seems to depend both on the physicians' favored diagnostic 'set' and on whichever aspect of the patient they happen to encounter." (Simpson, 1980, p. 261-262). The possible bias may have implications for treatment in light of the current debate about the usefulness of the borderline personality disorder diagnosis. Ettinger (1992) reviews literature that suggests that the experience of abuse common in self-mutilators

may be the most distinguishing factor and that the diagnosis of borderline personality disorder may lead to a lack of attention to abuse issues and post-traumatic stress disorder.

Kahan and Pattison (1984) suggest a solution to the difficult problem of diagnosing self-mutilation. They argue that a separate diagnosis of deliberate self-harm (DSH) be included in the next revision of the DSM as many self-mutilators do not fit the present diagnoses available and many are not characterologically disordered. They describe the symptoms, course, prevalence, population, predisposing factors and differential diagnosis criteria of DSH and present an extensive rationale for the inclusion of a separate diagnosis (Kahan & Pattison, 1984). A separate diagnosis of DSH would address the difficulty researchers and clinicians have encountered attempting to fit self-mutilators into current diagnostic categories and would remove the possible treatment bias stemming from traditional views that these patients are characterologically disordered. This diagnosis would also be useful in more clearly defining the group of subjects to be studied in research examining self-mutilation. Finally, the creation of a separate diagnosis

> would legitimize the efforts of clinicians, researchers, and grant givers, who are often constrained by the official nomenclature, to achieve a better understanding of these behaviors and to develop treatment for them. (Favazza, DeRosear & Conterio, 1989, p. 360)

Associated Symptoms and Experiences

Self-mutilation is correlated with many other symptoms and characteristics. Research supports correlations between self-mutilation and eating disorders (Darche, 1990; Favazza & Conterio, 1988; Feldman, 1988; Gustafson, 1991; Novotny, 1972; Pao, 1969; Schwartz et al., 1989; Simpson, 1980; Simpson & Porter, 1981; Woods, 1988), substance abuse (Brittlebank et al., 1990; Graff & Mallin, 1967; Novotny, 1972; Pattison & Kahan, 1983; Raine, 1982; Rosenthal, Rinzler, Walsh & Klausner, 1972; Schwartz et al., 1989; Simpson, 1975; Simpson, 1980; Simpson & Porter, 1981), antisocial behavior (Feldman, 1988; Pao, 1969; Schwartz et al., 1989), increased number of physical illnesses (Doctors, 1981; Rosenthal et al., 1972), and current sexual dysfunction such as frigidity and promiscuity (Gardner & Gardner, 1975; Graff & Mallin, 1967; Pao, 1969; Simpson, 1975).

Self-mutilators often have a history of physical or sexual abuse as children (Carroll, Shaffer, Spensley & Abramowitz, 1980; Darche, 1990; Ettinger, 1992; Favazza & Conterio, 1988; Grunebaum & Klerman, 1967; Leibenluft et al., 1987; Rosen et al., 1990; Simpson & Porter, 1981). They are more likely to come from families characterized by divorce, neglect or parental deprivation (Carroll et al., 1980; Friedman, Glasser, Laufer & Wohl, 1972; Graff & Mallin, 1967; Grunebaum & Klerman, 1967; Leibenluft et al., 1987; Pao, 1969; Pattison & Kahan, 1983; Rosen et al., 1990; Rosenthal et al., 1972; Simpson, 1975; Simpson & Porter, 1981). Simpson (1980) notes that while suicidal patients tend to have childhood experiences of complete parental deprivation due to death or divorce, self-

mutilators more often experience partial loss through emotional distancing and inconsistent parental warmth. Grunebaum and Klerman (1967) state: "The most striking features of parental behavior are the open displays of sexuality and aggression" (p. 528).

The Question of a Self-Cutting Syndrome

While most authors agree that self-mutilation should be examined separately from other self-destructive behaviors (Kahan & Pattison, 1984; Pattison & Kahan, 1983; Simpson, 1980; Walsh & Rosen, 1988) there is some question as to whether wrist cutting should be examined as a separate syndrome. Wrist cutting is the most common type of moderate self-mutilation (Feldman, 1988; Simpson, 1980). Several authors (e.g. Graff & Mallin, 1967; Pao, 1969; Rosenthal et al., 1972) have hypothesized a distinct syndrome characterized by repeated, superficial cutting, usually on the wrists and arms. Pao (1969) labeled this the "delicate self-cutting" syndrome and saw it as distinguishable from other types of self-destructive behavior. Delicate self-cutting is distinguished from the broad definition of self-mutilation because it is confined to specific types of acts (cutting) that are repetitive and cause only minor or moderate damage. This may be contrasted with suicidal cutting--defined as a single or few, deep coarse incision(s)--which is of high lethality and usually not repetitious (Doctors, 1981; Pao, 1969).

While delicate self-cutting may be clearly distinguished from suicidal acts or indirect types of self-destructive behavior, there is some question whether it should be considered a syndrome differentiable from other types of direct self-mutilation. Simpson

(1980) suggests that it may be different from other types of self-mutilation in its similarity with indirect self-destructive behavior in terms of intent and psychological state: "Although it [cutting] may seem to be more overtly self-injurious than other varieties of indirect self-destructive behavior, it shares many features with them, rather than with direct self-destructive behavior" (Simpson, 1980, p. 277).

Many authors appear to distinguish between self-cutting and other types of self-mutilation as they limit their studies only to self-cutting and define a "typical" self-cutter. The traditional cutter is defined by many authors as female, adolescent or young adult, single, usually from a middle to upper class background, and intelligent (Gardner & Gardner, 1985; Graff & Mallin, 1967; Kahan & Pattison, 1984; Raine, 1982; Rosenthal et al., 1972; Simpson, 1980). Darche (1990) found that self-cutters were three times more likely to be female, and Favazza and Conterio (1988) report that the average age of first self-harm in their survey respondents was 13.5 years.

Walsh and Rosen (1988) note that in the 1960's and '70's there was much support for a wrist cutting syndrome, differentiated from other types of self-mutilation primarily by the demographics of the people who engaged in it as described above. However, epidemiological studies by Clendenin and Murphy (1971) and Weissman (1975) challenged this notion. These studies found that about 40% of the cutters were male and that there was a large age range, although the majority were relatively young. Weissman

(1975) states that these epidemiological studies do not support the idea that wrist cutting is a separate syndrome.

While these epidemiological studies point out the need for further investigation and underline the difficulties involved in using primarily clinical samples, there are difficulties within these studies that make the conclusion that wrist cutting is the same as other types of self-mutilation somewhat suspect. The most important difficulty with these studies is that they did not distinguish between self-mutilation and suicide. Given the evidence for the distinctness of self-mutilation and suicide attempts (see above), this could be a significant ambiguity. Weissman (1975) also constrained her sample to those over 16. As many studies examined cutting in female adolescents as well as young adults (e.g. Doctors, 1981; Kafka, 1969; Pao, 1969; Raine, 1982), and Favazza & Conterio (1988) report that the average age of first self-harm in their survey respondents was 13.5 years, this constraint may have affected the mean age Weissman (1975) found for her subjects. Thus, limitations in these studies make it difficult to definitively conclude that self-cutters are indistinguishable from other self-mutilators in gender, age, marital status, and other demographic variables.

Furthermore, while there may not be a distinct wrist cutting syndrome defined by the demographics of the patient population, wrist cutting may be distinguishable from other types of self-mutilation in terms of intent, associated symptoms, and/or developmental experiences. Indeed, Weissman (1975) found that cutters differed from other suicide attempters in that they had fewer secondary symptoms of depression, were more likely to have

paranoid delusions, were less likely to appeal to others for help, and their acts had less potential risk to life. There may also be an interaction between these variables and demographic variables; self-cutters who fit the traditional picture may be a homogeneous group in terms of intent, associated symptoms, and/or developmental experiences. Cutters who do not fit the traditional demographic picture may be different and less homogeneous in terms of intent, associated symptoms, and/or developmental experiences. This is supported by research which indicates that males or older individuals who engage in self-cutting may present with an atypical functional and etiological pattern (Clendenin & Murphy, 1971; Graff & Mallin, 1967; Pattison & Kahan, 1983).

While wrist cutting may or may not be a separate syndrome in terms of patient demographics or other variables, it is the most common type of moderate self harm and perhaps the most closely studied. In addition, there is a surprising amount of agreement in the phenomenological accounts of self-cutting behavior that is not necessarily seen in descriptions of other types of self-mutilation (Doctors, 1981; Feldman, 1988; Gardner & Gardner, 1975; Graff & Mallin, 1967; Grunebaum & Klerman, 1967; Leibenluft et al., 1987; Miller & Bashkin, 1974; Nelson & Grunebaum, 1971; Pao, 1969; Podovoll, 1969; Rosenthal et al., 1972; Simpson, 1980; Woods, 1988). The precipitating event is most commonly the *perception* of an interpersonal loss. The individual generally reports feeling extremely tense, anxious, angry or fearful prior to cutting. Often, but not always, the individual reacts to the overwhelming emotion by experiencing depersonalization, feeling unreal and disconnected.

Isolation from others almost always precedes the actual act of self-cutting. Cutting is usually quite controlled. Razor blades are the favored implement and wrists and forearms are the most common targets of mutilation. The vast majority of mutilators report the absence of pain during the act. The anger, tension or derealization typically are ended by the self-mutilating behavior. Occasionally patients will report feeling guilty or disgusted after cutting, but the response of relief, release, calm, or satisfaction is far more common. Mutilators almost always cut alone and suicidal ideation or intent is quite rare.

Thus, there is some support for investigating self-cutting as a separate phenomena. The phenomenological accounts of self-cutting suggest homogeneity within these patients that may differentiate them from other types of self-mutilators or from self-cutters who do not fit the traditional demographic picture. Research on self-cutting as well as epidemiological studies suggest that patients who engage in this type of self-mutilation may be different in terms of intent or associated features. Finally, there may be an interaction effect such that cutters who fit the traditional demographic picture may be more homogeneous in terms of intent and associated features. It may be useful to initially confine one's investigation to cutting and to the traditional demographic constraints and create a starting point from which to generalize to or differentiate between other types of non-lethal, direct self-destructive behavior.

Eight Functional Models

The majority of the research and theorizing about the function of self-cutting appears to focus on generating reasons and

explanations for the behavior and relating these hypotheses to theoretical systems such as object relations theory, psychoanalytic theory or behavioral propositions. Favazza's (1989) review is quite comprehensive in its list of the varied motivations that patients and helping professionals associate with self-mutilation, and the psychological explanations that have been used to understand these motivations. However, there has been little attempt to integrate the various reasons in the literature into broader functional models or to evaluate these models. While the concepts of anger, low self-esteem, reaction to abandonment and lack of ability to self-soothe are clearly common to most, if not all, of the reasons reviewed, many of the reasons proposed are also significantly different from each other. When the many reasons in the literature are examined eight models emerge: behavioral, systemic, suicidal, sexual, expression, control, depersonalization, and boundaries (see Table 1, p. 14). The foundations of these models are common themes that unify some reasons and differentiate between others.

Behavioral Model and Supporting Theory

The behavioral model focuses on environmental factors that may have initiated as well as maintained the behavior. This model is based on the premise that cutting is reinforced either through external reactions resulting in secondary gain, or through the feeling of relief or release that cutting engenders. Underlying this model is the hypothesis that cutters either learned to link pain and care through early family experiences, or they learned about the benefits of cutting through vicarious reinforcement.

Table 1: Model Names, Abbreviations, and Summaries

Behavior	Beh	Cutting begins as a result of reinforcement of destructive behavior and linking injury with care. The behavior is maintained by reinforcement such as attention, social status and relief from emotional tension.
Systemic	Sys	Cutting is a way to express the systemic dysfunction of the family or environment. The cutter protects the system by expressing the inexpressible and taking responsibility for it.
Suicidal	Sui	Cutting is a suicide replacement.
Sexual	Sex	Cutting stems from conflicts over sexuality and menarche.
Expression	Exp	Cutting stems from the need to express or externalize overwhelming anger, anxiety or pain that is seen as unable to be expressed more directly.
Control	Con	Cutting is an attempt to control affect or need. Cutting helps actively control the affect by making it concrete or provides punishment for affect that is perceived as out of control.
Deperson-alization	Dep	Cutting is a way to end or cope with the effects of depersonalization that results from the intensity of affect.
Boundaries	Bou	Cutting is an attempt to create a distinction between self and others. It is a way to create boundaries or identity and protect against feelings of being engulfed or fear of loss of identity.

The attention and concern of others can be powerful reinforcers of behavior. In Offer and Barglow's study (1960) self-mutilating patients included attention and social status among peers (as a result of being able to endure pain) as two reasons for self-mutilating behavior, and other authors have emphasized the

secondary gains of attention and control over others (Bennum, 1984; Favazza, 1989; Podovoll, 1979). Simpson (1980) describes competitions among patients for who has the most severe or the greatest number of cuts; he states: "Although wrist-slashing is a private ritual with primarily internal motivations, patients may soon discover and begin to value the rewards of secondary gain" (Simpson, 1980, p. 268). In addition, self-mutilation may be used as a way to control others; in particular, the patient may have learned that cutting evokes a response from significant others that precludes their leaving, or influences them to better meet the patient's needs (Favazza, 1989), thus providing negative or positive reinforcement for the cutting behavior.

Social learning theory, with its emphasis on vicarious reinforcement, self-reinforcement, the contribution of family relationships, and the importance of modeling (Muuss, 1982) may be especially relevant to the behavioral view of the function of this behavior. For example, the concepts of modeling, imitation and identification could be applied to the idea that adolescents learn through their parents' models that injury and care are associated: "the child may learn that the only form of attention and interest that can be received from a parent is physically painful...[thus, the] child may learn to physically stimulate and care for the 'self' by injuring that 'self'" (Simpson & Porter, 1981, p. 436). The cutting behavior could originate in this association and modeling and could then be self-reinforced by decreased tension or ending dissociation.

Social learning theory also emphasizes the interaction of dependency and aggression and the effects of early family relationships on this interaction. Muuss (1982) states:

> One basic assumption of Bandura and Walters' study is that antisocial aggression develops from a disruption in the adolescent's earlier dependency training in relationship to parents. Dependency needs could be frustrated by lack of affectional nurturance, by parental rejection, or by lack of close dependency ties with one or both parents. An impairment in the development of healthy dependency relationships may directly contribute to the development of hostility and aggressive behavior. (p. 284)

This assumption that aggression is related to dependency is supported by previous research showing that cutting is precipitated by a perceived interpersonal loss, as well as by the correlational data on self-mutilation and distant or disrupted family relationships. In addition, social learning theory contributes to our understanding of the contagion effect (Favazza, 1989; Simpson, 1980) through the concept of modeling and reinforcement as well; individuals may observe that cutting behavior is rewarded and then imitate the behavior. The application of social learning theory to adolescent development accounts for the shift from parents to peers in the search for appropriate models (Muuss, 1982),. Imitating a fellow patient's coping mechanism may therefore be more likely in adolescence, especially if vicarious reinforcement takes place and the patient sees the cutter receiving attention, concern or symptom relief.

The Systemic Model and Supporting Theory

The systemic model focuses on the cutting as a symptom of the family or environmental dysfunction. This model relates cutting to the attempt to maintain an acceptable environment or a familial homeostasis. In this model, cutting serves to express or deflect attention from systemic (i.e. familial, environmental or societal) dysfunction. The system is often the family, but could also be the hospital ward or residential home. The system also encompasses dysfunctional aspects of the larger societal context in which it is embedded.

Research that examines the societal context of self-mutilation may be generalized to the family context to provide support for this model. If self-mutilation serves a purpose within the larger societal system, one might hypothesize that it also serves similar functions in the smaller familial system that reflects so many of the cultural and societal values. Several authors (Favazza, 1989; Menninger, 1938; Podovoll, 1969) note that self-mutilation, in the broader sense of the word, has historical and cultural precedence and, at times, support. Thus, Favazza (1989) discusses self-mutilation as possibly akin to shamanic suffering, religious rituals and rites of passage and states: "Pathologically troubled adolescents may be demonstrating behavior that has in other societies been elaborated into a culturally acceptable means of resolving the maturational issues faced by all adolescents" (p. 143). Podovoll (1969) examines how cutting serves the needs of the system of the inpatient environment in which self-mutilation is often seen. He acknowledges the intrapersonal conflict of the adolescent but focuses on the interpersonal perceptions and

interactions. Self-mutilators generally perceive themselves to be isolated and disconnected from others; they rarely view their behavior as a reaction to an interpersonal event, and they have extreme difficulty perceiving that their cutting affects other people (Podovoll, 1979). Nonetheless, within the hospital, as within the family, the self-mutilator expresses conflicts and feelings that others experience but repress or defend against more successfully:

> The self-mutilator can incorporate into his actions patterns which, to a greater or lesser degree, remain unarticulated in most of us. That is, such patterns already exist in muted intensities within the patient's social field. As such, he may even perform a service to his culture in his dramatic expression of these patterns which are felt to be intolerable within the self. Still other patterns invoked are those which elicit silent levels of admiration and envy. (Podovoll, 1969, p. 219)

Podovoll comments on the societal value placed on martyrdom, pain endurance, asceticism and mortification of sensuality and the body; self-mutilation is reinforced by the culture as something honest, authentic, disciplined or pure, as mutilation in other cultures may be more explicitly valued. Podovoll (1969) summarizes the systemic view of the function and maintenance of self-mutilation:

> What we see then are really two levels of compliance that exist within the social field of these patients. At one level we find the symptom formation perpetuated: either for purposes of protecting the community from something less tolerable, or in the service of continued relationship with the patient and thereby protecting the patient from the community. At another level we find these patients engaging the more poorly integrated aspects of ourselves

> and patterns in our culture that can lead to collusion and even respect and envy. (p. 221)

Podovoll's analysis of inpatient systemic dynamics may be extrapolated to a family context. The cutter may be using self harm to protect the family and express the difficult issues of other family members. In addition, the family may be subtly supporting the behavior as a way to maintain the homeostasis of the family system or as a channel for difficult conflicts or emotions.

The Suicide Model and Supporting Theory

As discussed above, most authors agree that self-mutilation is distinct from suicide in intent, lethality, phenomenology and associated features. However, some authors feel that self-mutilation is an active way to avoid suicide. The suicide model of cutting may be more aptly termed the anti-suicide model, as cutting is seen as a way to avoid total destruction. Firestone & Seiden (1990) state:

> In a sense, people are able to achieve an illusion of mastery over death by committing small suicides on a daily basis. These partial or chronic suicides are referred to here as 'microsuicides' and encompass those behaviors, communications, attitudes or lifestyles that are self-induced and threatening, limiting, or antithetical to an individual's physical health, emotional well-being or personal goals. (p. 207)

This model sees self-mutilation as a coping mechanism, rather than an attempt to disconnect entirely.

Menninger (1938) sees self-mutilation as a compromise between the life and death drives. He states:

> ...self-mutilation is the net result of a conflict between (1) the aggressive destructive impulses aided by the super-ego, and (2) the will to live (and love)....[W]hile apparently a form of attenuated suicide, self-mutilation is actually a compromise formation to avert total annihilation, that is to say, suicide. In this sense it represents a victory, even though sometimes a costly one, of the life-instinct over the death-instinct. (p. 250)

Thus, the suicide model of cutting focuses on the behavior as an active coping mechanism used to avoid suicide.

The Sexual Model and Supporting Theory

The sexual model of cutting emphasizes the connection between cutting and conflictual feelings about sexuality. This model proposes that cutting offers sexual gratification, punishes or attempts to avoid sexual feelings or actions, or attempts to control sexuality or sexual maturation.

Many authors connect self-mutilation with sexuality and sexual development (Daldin, 1988; Doctors; 1981; Favazza, 1989; Offer & Barglow, 1960; Simpson, 1980; Woods, 1988). Woods (1988) sees cutting as a perverse sexual gratification while Daldin (1988) and Feldman (1988) contend that self-mutilation is a masturbation equivalent also encompassing punishment for this desire.

Friedman et al. (1972) relate cutting to the psychoanalytic idea that the changes associated with puberty initiate a revival of Oedipal issues (A. Freud, 1958; Josselson, 1980). They state that the increased sexual fantasies about the mother and the accompanying aggressive impulses may be experienced by self-mutilating adolescents as overwhelming. Self-mutilators may feel "forced" by

their bodies to have these fantasies; cutting is an attempt to destroy or purify the body which is seen as separate from the self:

> ...in attacking the body with the aim of mutilating oneself, the unconscious fantasy is of destroying the genitals seen as the source of the urges; through displacement, whichever part of the body is attacked then represents the genitals; in the suicide attempt, it is the whole body which is attacked as the source of the urges. While a state of calm precedes the actual suicide, in self-mutilation, the patients describe this state of calm as following the act. We believe this state of calm might be understood as a relief that, despite the injury, the genitals are safe. (Friedman et al., 1972, pp. 182-183)

Feldman (1988) agrees that cutting may serve as a way to avoid real castration or destruction of the genitals through enacting the symbolic castration of cutting.

Cutting is also viewed as a controlled penetration (Doctors, 1981; Novotny, 1972). Doctors (1981) states that the early sexual activity and the high number of rapes experienced by her subjects were provoked by cutters not only to focus sexual feelings but also as attempts to relieve anxiety about these feelings by taking control over them. She sees cutting as a similar attempt to take control of penetration and aggressive and sexual impulses:

> Sensations from the inside were concretized and localized at the wound....Self-cutting thus concretely represented the insult to self she experienced and her ability to counteract it. To the extent that genital excitement had become a focus for her tension (and perhaps confused with her anger), the cutting could as well be

conceptualized as a penetration which she controlled. (p. 457)

Novotny (1972) hypothesizes that self-mutilators experienced conflicts and difficulties in the earliest stages of psychosexual development that led to serious disturbances in interpersonal relationships as well as difficulties in sexual development embodied in cutting as self-penetration. This destructive self penetration may be related to the intense desire for connection and dependency which was never met in infancy, resulting in a denial of this need and guilt for experiencing the desire. Self-mutilation may thus be a punishment not only for sexual feelings but also for basic dependency feelings and neediness.

Cutting behavior has also been connected to negative reactions to menarche (Doctors, 1981; Rosenthal et al., 1972). In addition, Rosenthal et al. (1972) found that cutting had not occurred before menses in their subjects, and 60% of the cutting episodes they investigated occurred during menses. These authors hypothesize that cutting is a "means of dealing with genital trauma and conflict centering around menstruation" (Rosenthal et al., 1972, p. 1367) where the conflict is displaced from the genitals, and the bleeding is exposed and controlled, turning passive into active.

Many authors note the sado-masochistic character of self-mutilation, where the mutilator can control both aspects of the relationship (Asch, 1988; Feldman, 1988; Roy, 1978). This is connected to the same power dynamics and dependency/autonomy needs that sado-masochistic sexualized acts are. Self-cutting may be akin to masochistic acts in the control issues that the cutter is

experiencing as well as the use of self-destructive behavior as an integral part of intimate relationships. Asch (1988) differentiates masochistic perversion or sexual masochism from masochistic character or moral masochism. He states that the latter is unaware of the pleasure in exciting sexual gratification and thus the behavior may not directly reflect sexual derivatives. Asch (1988) emphasizes that both types of masochistic individuals are concerned with power and the need to be in control of the painful or unpleasurable relationship or act. Anecdotal evidence also links sexual masochism and self-cutting as it suggests that self-mutilating individuals may engage in sado-masochistic sexual acts as a transitional stage between cutting and recovery (Lydia Rachenberg, personal communication, March, 1992).

The Expression Model and Supporting Theory

The expression model views self-mutilation as stemming from the need to express or internalize excessive anger, anxiety or pain that is caused by the perceived abandonment. This model sees cutting as serving as a basic way to express overwhelming and internally intolerable affect, and a redirection of anger from the other onto the self (Darche, 1990; Favazza, 1989; Friedman et al., 1972; Gardner & Gardner, 1975; Leibenluft et al., 1987; Offer & Barglow, 1960; Pao, 1969; Podovoll, 1969; Raine, 1982).

Leibenluft, Gardner & Cowdry (1987) conceptualize cutting as a need to feel a real physical pain as opposed to just an emotional pain; this conceptualization is not congruent with the consistent reports of no pain upon cutting, but it may be that cutters need to have physical evidence of their injury in order to feel that their emotions

are real, justified or able to be tolerated. Self-mutilation may translate the feeling into an external injury which validates and expresses the emotion. One of Ettinger's (1992) subjects expressed this function:

> I can look at these marks and say, "This is how badly I felt and it was real," because a big thing I'm going through right now is feeling like, like I'm not real. Like my feelings aren't real....So, when I can look and see those marks, I can say to myself, "No, this is real, because look at this--this is like a real thing that you did. (p. 77)

In this model, anger is not directed outward to the abandoning object, but is turned inward against the self, in a dynamic akin to psychoanalytic explanations of depression (Asch, 1971; Darche, 1990; Ettinger, 1992; Favazza, 1989; Friedman et al., 1972; Offer & Barglow, 1960; Raine, 1982; Woods, 1988). It is not the object that is hated for leaving, but rather the self, for both the anger and the need. Cutters may believe that it is better to hurt the self than to hurt others (Favazza, 1989; Simpson & Porter, 1981), perhaps because to externalize the anger or need would destroy the object (Podovoll, 1969; Simpson & Porter, 1981).

The expression model focuses on the inability of the patients to express or tolerate anger. The need for expression may be a need both to externalize the emotion, as well as to express the affect to others:

> Self-mutilation serves a variety of purposes for these teenagers, in that it appears to be a generalized reaction to stress within relationships. Self-mutilators use these acts to reduce their own feelings of frustration, anger, or

> anxiety, while at the same time communicating their feelings to others. These individuals often have difficulty expressing their feelings verbally to others. Instead they consistently report experiencing relief from feelings such as anger immediately following self-mutilation. (Rosen et al., 1990 p. 182)

Doctors (1981) uses object relations theory to further explain the relationship between expression and self-mutilation. She reviews Winnicott's ideas that it is when an infant's wish is made real that the infant develops the capacity to use symbols and states that the inarticulateness of self-mutilators relates to a failure of trust and the associated ability to perceive symbols as a means to move beyond the feeling of omnipotence and hopelessness. Doctors (1981) observed that when her self-mutilating patients expressed feelings, they tended to be discounted or disconfirmed by their parents, resulting in a lack of faith that expressions of needs or desires would be environmentally responded to.

Sarnoff (1988) discusses the mechanism through which the lack of symbolizing function may contribute to self-mutilation:

> One of the elements that potentiate adolescent vulnerability to masochistic conflict resolutions is a failure in the development of the symbolizing function. There is a failure in negotiating the developmental shift from evocative to communicative symbols. There is normally a shift from the use of symbols that evoke moods to the use of symbols that communicate information in expressing drive manifestations. The more primitive evocative symbols continue to evoke feelings and memory of trauma in the service of discharge without mastery. They are not used to

> communicate or for reparative mastery. They are not viewed from a therapeutic distance. (p. 211)

The expression model contends that self-mutilation is related to this inability to use symbols to express affect. Self-mutilation is used as a "primitive evocative symbol" that discharges the feeling but does not communicate it or obtain distance or mastery over it.

The Control Model and Supporting Theory

The control model of self-mutilation also focuses on emotion, but emphasizes emotion in relation to the patient's need to control rather than express. Feelings of extreme helplessness result from the perceived abandonment, along with a need for control over the anger, the need and the environment. This model views cutting behavior as an attempt to regain control by channeling the anger at the abandoning object actively against the self, or by enacting the anger that is perceived to be coming from the object and resulting in abandonment (Darche, 1990; Favazza, 1989; Friedman et al., 1972; Raine, 1982; Woods, 1988). Dubovsky (1978) states: "...the wish of patients who feel helpless or victimized to assert control over a part of themselves may play a role in many forms of self-mutilation" (p. 1241).

Raine (1982) and Doctors (1990) hypothesize that cutting may reflect a need to enact what is passive. Raine states: "It may be that what is of importance is the turning of a passive wound, castration, and menstruation, its reminder, into an active one controlled by the patient" (p. 7). While her explanation is grounded in psychoanalytic theory concerning psychosexual development, one may also view the "wound" discussed as the wound resulting from perceived

abandonment, and thus relate this theorizing more explicitly to the phenomenology of the behavior. Doctors (1990) agrees that cutting is used to regain control by taking action:

> ...the symptom of self-cutting can be understood in the context of developmental disturbances which contribute to the clinical features seen in such patients: a heightening of feelings of frustration and simultaneously, a heightened intolerance for feelings of tension...and a definite propensity to turn passively experienced diffuse distress into active, focal experiences designed to achieve a feeling of control over self and, thereby, a feeling of relief." (p. 445)

Control is gained by cutting as the action externalizes the emotions turning them into something concrete and specific and enabling the patient to distance from them. Another of Ettinger's (1992) subjects commented on this aspect:

> When you're dealing with emotions, you don't know how long you're going to be feeling what you're feeling. You don't know what to do to make it go away. You're just left with this timeless thing--you just don't know anything...when I cut myself, it bleeds. It hurts the first day, the second day it itches....[then] it just kind of scabs and goes away....I knew that once I cut myself, I almost knew the time lines of when that physical pain would go away. Whereas [with] my emotional pain I haven't a clue. (p. 78)

Finally, cutting may also be punishment for having feelings or needs that are out of control:

> Well, I think that what happens for me with the abuse, emotionally, is that I always felt that it was my fault.

> And, one of the reasons why it was my fault in my mind was that, like I dared to want attention and that I was too needy so my father was like rebelling against it. That's how I thought about it. And it was too frightening for me as a kid to be angry at a parent. You know, because I was a kid and I needed my parents to protect me. So I had to like make sure they were okay, so whenever anything would go wrong it had to be my fault because I felt safer that way. So when I would get mad at my parents, I would get mad at myself for being mad at them. And usually I was mad at them because of some way or another they weren't meeting my needs. So it became sort of an emotional life or death whenever I felt like I needed something emotional. To me love was a threatening situation in my mind. So, it was just safer to be mad at me. (Ettinger, 1992, p. 71)

Simpson (1980) notes that Anna Freud suggested that being the victim of aggression is the first developmental experience, and through appropriate interactions with the mother, the child learns to externalize their anger. It is quite possible that self mutilating adolescents, with their dysfunctional family backgrounds and history of abuse, lack the developmental experience needed to produce the ability to externalize anger and defend against the intense need that reemerges in adolescent years.

The Boundaries Model and Supporting Theory

The boundaries model of cutting focuses on the need to affirm the boundaries of the self (Carroll et al., 1980; Favazza, 1989; Feldman, 1988; Kafka, 1969; Podovoll, 1969; Raine, 1982; Simpson, 1980; Woods, 1988). In this model, the perceived abandonment creates intense emotions that threaten to engulf the self of the patient; this loss of self is combated by self-mutilating. Cutting

serves to define the self and create a distinct and separate self representation, differentiating the self from other (Carroll et al., 1980; Favazza, 1989; Feldman, 1988; Kafka, 1969; Podovoll, 1969; Raine, 1982; Simpson, 1980; Woods, 1988).

Woods (1988) summarizes many of the ideas behind the boundaries model, that self-mutilation stems from an inability to differentiate self from other. He states that perceived abandonment leads to unbearable feelings of isolation that result in feeling unreal. Anger at the other person becomes shame at one's own neediness driving the other away. Needs are felt as overwhelming because they are, indeed, a wish for merger. Anger quickly becomes rage as the individual is confronted with the reality of not merging and the threatened loss of self. This anger is directed at the self, producing a fusion of inside and outside, self and other and pleasure and pain (Woods, 1988). Carroll et al. (1980) agree:

> We can also view self-mutilation in terms of a self theory, in which the impulsive self-destructive act becomes an attempt to overcome the intense "depletion anxiety," i.e. fear of fragmentation or destruction of the self. Narcissistic patients who have been deprived of gratifications required for the development of a cohesive self may exhibit such behavior. (p. 853)

As suggested above, the boundaries model is rooted in theory that suggests that these patients were unable to adequately separate or individuate from their mothers, primarily because the attachment was not secure enough in the first place (Carroll et al., 1980; Friedman et al., 1972; Pao, 1969; Walsh & Rosen, 1988). Doctors (1981) states that self-mutilators experience an early failure of

parental empathy. This failure interferes with the child's ability to achieve stable object representations, so that boundaries become blurred and fear or merger occurs. The adolescent need for autonomy and identity development revives the initial separation/individuation (Erikson, 1968; Josselson, 1980) issues. However, the failure to adequately negotiate the infant's separation/individuation stage leads to current separation causing a feeling of loss of self as the self is still merged with the other (Carroll et al., 1980; Simpson & Porter, 1981; Walsh & Rosen, 1988). Cutting creates or helps to maintain a separate and unique sense of self:

> Paradoxically and understandably, they were unable to detach themselves from those to whom they had never felt attached. Their sense of isolation was overwhelming. In such instances, bleeding became for them real, tangible evidence that 'I *do* exist *somewhere* in this world. (Simpson & Porter, 1981, p. 435)

Raine (1982) hypothesizes that the wound or the scar may be a means to establish a sense of identity and Simpson (1980) theorizes that the internal process of cutters may include a belief akin to "I bleed, therefore I am." Podovoll (1969) agrees that self-mutilation may be used to create a sense of identity, reflecting that these adolescents are often viewed by others in terms of their cutting behavior: they are known as "cutters" and *defined* by this symptom. Cutting may also help to prove independent identity and self-will through emphasizing the personal ability to die and providing proof of a self-directed act.

Finally, many object relations theorists see cutting, cutting implements, blood, or scars caused by cutting as transitional objects

used to negotiate the reenactment of the separation/individuation process (Doctors, 1981; Josselson, 1980; Kafka, 1969; Simpson, 1980; Woods, 1988). Self-mutilation is an intermediate experience, an attempt by the adolescent to simultaneously separate and connect the inner and outer experience: "Blood was described by the patient as a transitional object. In a sense as long as one has blood, one carried within oneself this potential security blanket capable of giving warmth and comforting envelopment" (Kafka, 1969, p. 209). The body serves as a transitional object between living and dead, part and whole, inside and outside, self and other (Simpson, 1980).

The Depersonalization Model and Supporting Theory

The depersonalization model of self-mutilation is the only one that explicitly addresses the dissociation that has been observed so often. This model agrees that the perceived abandonment causes intense anger and need, but these emotions are so overwhelming that a state of dissociation follows. Self-mutilation effectively ends the depersonalization or feelings of unreality (Favazza, 1989; Ettinger, 1992; Miller & Bashkin, 1974; Pao, 1969; Raine, 1982; Simpson, 1975; Simpson, 1980):

> Patient: When I go through changes and cut-up I feel better right away.
> Doctor: What do you mean by 'changes'?
> Patient: You know--like I'm not there; like I'm not real. When I start to cut-up and see the blood and then when the cuts start to hurt, it ends. I'm back inside myself. (Miller & Bashkin, 1974, pp. 640-641)

The depersonalization model focuses on creating or maintaining a sense of self or identity in the face of overwhelming internal emotion, rather than in the face of merger with another person as in the boundaries model. Although it is unclear by what specific mechanism cutting accomplishes the end of the depersonalized state, it appears that the blood may be a possible agent:

> Depersonalization and unreality preceding the cut was described by 22 of the 24 cutters; non-cutters did not describe this experience. Blood often seems to have a special significance for them in mediating reassociation and a return to a normal experience of reality... (Simpson, 1970, p. 432)

Simpson (1980) hypothesizes that the color shock of the red blood may contribute to ending depersonalization. In addition, the scars left from cutting may serve to create a continuity of existence for the patient, connecting episodes of depersonalization or preserving past events or emotions that could not be integrated into the sense of identity (Miller & Bashkin, 1974; Simpson, 1980).

Miller and Bashkin (1974) apply object relations theory to their understanding of the function of self-mutilation. They focus on the depersonalization and state that the prerequisite to depersonalization is narcissistic object relations in childhood. This leads to a self representation that is not clearly differentiated from object representations, causing shifts between, and fusions of, self and object images, as in many of the theories supporting the boundaries model. Miller and Bashkin (1974) agree that self-mutilators have failed to obtain object constancy and view the etiology of self-mutilation in the following sequence of internal events: the

threatened expression of deprivation, rage and anxiety leads the disintegrating ego to release the punitive introject of the parent. The recognition of the infantile, passive needs is incompatible with the grandiose, aggressive self image, resulting in the punitive parent introject devaluing and disowning the disintegrating ego. Self-mutilation results, rooted in the sadistic parent introject punishing the needs and turning passive into active, while simultaneously protecting the object:

> The self-mutilation enables him to deny with one stroke the painful reality that he is not capable of significant, purposeful, independent, goal-directed action, while at the same time it spares from direct, overt attack and possible annihilation, the object which is the source of his frustration and which is now endangered by his rage. Thus, the self-mutilation deflects the rage, protects the objects (thereby maintaining the possibility of future gratification), punishes the self for not being its own ego ideal, and permits a temporary, though grandiose, restitution. (Miller & Bashkin, 1974, p. 645)

Developmental Issues

The eight models outlined above appeared to integrate the various reasons researchers and theoreticians use to explain delicate self-cutting. However, there had been no empirical study examining whether these models accurately reflect the data seen by therapists working with these patients. Investigating which, if any, of these models is most commonly endorsed by therapists provided a more empirically grounded theory of the symptom. Furthermore, this study briefly explored therapists' understanding of the

developmental issues being dealt with by the patients. The purpose of this exploratory piece was to place our understanding of this behavior in a developmental context. While most recent research has largely disproved the idea that normal adolescence is characterized by "storm and stress" (Bandura, 1964; Feldman & Gehring, 1988; Hill, 1980; Offer & Offer, 1975; Paulson & Hill, 1988; Powers, Hauser & Kilner, 1989), Powers, Hauser & Kilner (1989) state that 10% to 20% of adolescents exhibit severe emotional disturbance. The eight models presented above appeared to be related to adolescent developmental issues such as a) learning to modulate emotions as physiological changes create intense experiences that are new and can be overwhelming; b) struggling with the need to control the environment, as this is directly related to the task of developing autonomy, independence and ego mastery; c) creating a stable identity; and d) dealing with emerging sexuality. It was hoped that empirical data on therapist's views of the developmental issues of actual clients would clarify the relationships between self-cutting and adolescent development.

CHAPTER II

PRETEST

The models discussed above were created through examining the reasons for self-cutting put forth in the literature and grouping these reasons according to common unifying themes. These common themes became the model summaries, while the specific reasons from the literature became the functional hypotheses that made up each model. The purpose of the pretest was to examine whether the specific functional hypotheses conceptually (as opposed to actually) reflected and differentiated between the proposed integrative models. These hypotheses were refined in order to best differentiate between models; hypotheses that did not clearly reflect a model but seemed rather to relate to an underlying issue such as anger were not used. The purpose of the pretest was to determine that the groupings of the hypotheses (see Appendix A) and their associations with the unifying themes were not due to a subjective bias of this researcher.

Method

Subjects consisted of 54 faculty and graduate students in the clinical division of the psychology department at the University of Massachusetts at Amherst. APA guidelines for ethical recruitment and treatment of human subjects were observed, and approval of the University of Massachusetts Human Subjects Committee was obtained. Subjects received a cover letter (see Appendix B) and a de-identified pretest questionnaire (see Appendix C) in their

departmental mailboxes. The cover letter included a summary of the general issues involved in delicate self-cutting, an explanation of the purpose of the pretest and a brief description of the main study. The questionnaire consisted of a brief summary of the essential elements of each of the eight models and 28 functional hypotheses for delicate self-cutting thought to be unified by these models. Subjects were asked to classify each of the hypotheses into one of the eight models or into an "other" category. Subjects were encouraged to complete the questionnaire within two weeks; no questionnaires were received after this time. A summary of the final study was offered to pretest subjects upon written request. Sixteen subjects completed and returned the questionnaire, yielding a 29.6% return rate.

Results

The percent of subjects placing each hypothesis into each of the nine response categories was computed (see Table 2, p. 37). A multistage analysis was used to identify which hypotheses could be regarded as acceptably differentiating between models. The first stage of analysis examined whether any hypothesis was categorized by a majority of subjects into a model other than that with which it was hypothesized to relate. In no instance did the rating of the majority of subjects reflect a model other than the one expected. The second stage further determined whether the hypotheses adequately differentiated between the models by examining how highly a hypothesis was related to its model. An acceptable hypothesis was

Table 2: Percentage Matrix for Pretest[1]

	Beh	Sys	Sui	Sex	Exp	Con	Dep	Bou	Other
1				***100***					
2	***93.75***				6.25				
3					***87.5***	9.375		3.125	
4					6.25	***85.5***	6.25		
5				***87.5***		6.25		6.25	
6		6.25				***53.125***	6.25	28.125	6.25
7		***100***							
8							***93.75***	6.25	
9								***100***	
10	***100***								
11			***100***						
12					***87.5***	12.5			
13				***93.75***					6.25
14				***93.75***		6.25			
15			12.5			***71.875***		3.125	12.5
16								***100***	
17		***100***							
18	6.25				***75.0***	6.25	6.25	6.25	
19						***93.75***			6.25
20							***100***		
21								***100***	
22	***40.625***	9.375	6.25			25.0			18.75
23		6.25				***62.5***	6.25	12.5	12.5
24					6.25	6.25	18.75	***68.75***	
25	***58.333***	27.083							14.583
26	6.25			***93.75***					
27					12.5	***68.75***	18.75		
28							6.25	***87.5***	6.25

[1]See appendix 1 for abbreviations and model summaries. See appendix 3 for numbered hypotheses. Bold italics indicate the model with which each hypothesis was expected to be associated. Underlined hypothesis numbers indicate a hypothesis that did not fit the inclusion criteria (see results section below).

one which was classified into its expected model by a minimum of 70% of subjects (11.2 out of 16 subjects).

It was expected that the various hypotheses of delicate self-cutting would all sort into the models that they theoretically generated (see Appendix A). Twenty-two of the original 28 hypotheses did so.

Six hypotheses (see Table 3, p. 39) did not meet the inclusion criteria. These hypotheses were examined in the context of the other hypotheses and the models as wholes in order to determine whether they could be rejected without significantly affecting the adequacy of the hypothesis set in representing the model. Three considerations were used in making this decision. The first consideration was whether the content of the questionable hypothesis was unique, in that its content was not included in any of the accepted hypotheses. This was determined by returning to the literature and examining whether the original intent of the hypothesis was based on reasons in the literature upon which another, accepted hypothesis was based. The second consideration was whether the intended content of the hypothesis did indeed differentiate between models. The purpose of the hypotheses was to uniquely describe the models with which they were associated; the pretest was expected to point to possible conceptual errors, to determine which hypotheses were not adequately differentiating between models. The literature was again re-examined to determine whether the reason upon which the hypothesis was based was associated with themes underlying more than one model. The third consideration was whether deletion of the questionable hypothesis would significantly imbalance the

Table 3: Rejected Functional Hypotheses

Etiological Hypothesis	Proposed Model	Other Models
6. Cutting is an attempt to control anger of another person that is directed at the cutter. The anger from others is turned into anger at self that can be controlled and will not totally destroy the self.	Con: 53.125%	Bou: 28.125% Sys: 6.250% Dep: 6.250% Other: 6.250%
22. Cutting is an attempt to actively control others: "if you leave, I will hurt myself."	Beh: 40.625%	Con: 25.000% Other: 18.750% Sys: 9.375% Sui: 6.250%
23. Cutting is a way to control feelings of abandonment; cutting helps the patient withdraw from others before others can withdraw from the cutter.	Con: 62.500%	Bou: 12.500% Other: 12.500% Sys: 6.250% Dep: 6.250%
24. Cutting and blood prove independent existence; it is a solitary act with concrete consequences and proof of own will.	Bou: 68.750%	Dep: 18.750% Exp: 6.250% Con: 6.250%
25. Early family experiences link pain and care through physical abuse and forgiveness cycle. Cutting is an attempt to reenact this cycle and produce caring by producing pain.	Beh: 58.333%	Sys: 27.083% Other: 14.583%
27. Cutting is an attempt to control the intensity of affect by turning it into something external that can be distanced from.	Con: 68.75%	Dep: 18.75% Exp: 12.5%

number of hypotheses reflecting each model, perhaps deleting the majority of the hypotheses within one model or creating an inordinate difference between models (e.g. resulting in three or four models with only one hypothesis and two or three with five or more).

Upon examination, it was decided to reject all six hypotheses without further investigation. Some of these hypotheses were rejected on the basis of similarity to other accepted hypotheses, such as #27 which is very much like #4: "Intense affect is experienced as being out of control. Cutting is an attempt to control affect by channeling it into something concrete and specific." Others were rejected as it was determined that they did not truly differentiate between models and were not representative of the main idea of the model as a whole. Examples of this are the rejection of #23, the content of which reflects boundary and interpersonal issues as well as internal control issues and #25 which is behavioral in its conditioning sequence but is confounded with ideas that are more reflective of the systemic model. The most questionable rejection is that of #6, as the content reflected in this hypothesis is relatively unique and it is discussed in the theoretical literature, especially by object relations theorists, as a possible important determinant. However, it was felt that this item did not, in fact, reflect the control model and perhaps was not truly associated with any model, but rather with the underlying anger and poor self-esteem that is acknowledged within all of the models. Investigating the many facets and causes of this anger and low self-worth may be a worthwhile future direction but was not the intent of this study.

In terms of balance, the deletion of the six items created a more balanced picture, overall (see Table 4, p. 41). The range of number of hypotheses in each model was reduced from 6 to 5. No

Table 4: Distribution of Functional Hypotheses

	Beh	Sys	Sui	Sex	Exp	Con	Dep	Bou
Initial Total	4	2	1	5	3	6	2	5
Reject	2	0	0	0	0	3	0	1
Final Total	2	2	1	5	3	3	2	4

model was reduced by more than half and no model was reduced to only one hypothesis (the suicide model had started with only one hypothesis).

Discussion

The data from the pretest generally supported the expected differential associations between specific hypotheses and the general models which unified them. While the main purpose of this pretest was to evaluate the perceived associations between hypotheses and models, the pretest also contributed to a refinement of the models themselves through the process of the examination of the six rejected items and their discriminating ability. The control model became more clearly an intrapsychic model, concerned with control of one's own affect and not with control of other people or other people's affect. The behavioral model became more focused and traditional, dealing more with reinforcement and secondary gain in the present and less with long term developmental or systemic

issues. The accepted 22 hypotheses were those used in surveying therapists about their understanding of the reasons behind delicate self-cutting in their patients.

CHAPTER III

METHOD

Subjects

Initial subjects consisted of a total of 500 therapists: 250 from the *National Register of Health Service Providers in Psychology* and 250 from the *National Association of Social Workers Register of Clinical Social Workers.* Three hundred subjects (150 from each source) were recruited by mail in mid-January, 1993 and 200 subjects received mailings in early March, 1993. APA guidelines for ethical recruitment and treatment of human subjects were observed, and approval of the University of Massachusetts Human Subjects Committee was obtained.

Subjects selected for the sample were limited to those therapists who indicated that they provide individual treatment to adolescents (defined in the *National Register* as ages 13 to 17; not specifically defined in the *NASW Register*) and adults (defined by the *National Register* as ages 18 to 64; not specifically defined by NASW). The sample was limited to those serving adolescents as well as adults as the literature reviewed above indicates that delicate self-cutting is primarily an adolescent or young adult phenomenon; thus, therapists who do not see adolescents are significantly less likely to have treated a delicate self-cutter. The sample was limited to those providing individual therapy, as the literature suggests this type of therapy is most commonly used with delicate self-cutters and individual treatment is usually more in depth; it is therefore more likely that a therapist providing individual treatment would have the

kind of detailed knowledge that is being investigated in this study. Furthermore, the conceptualization of the function behind cutting may be very different for those clinicians using group or family therapy.

Using the *National Register* and the *NASW Register* meant that a nationwide population was available, increasing generalizability of results and decreasing possible bias from geographical trends and preferences (Sudman, 1983). These sources provided access to two of the major professional groups primarily focused on providing licensed psychotherapy were represented. However, using these sources to generate a sample meant that psychiatrists providing therapy were excluded. This exclusion had both advantages and limitations. The advantages were that the resulting sample had a more homogeneous training background, were more likely to have been explicitly trained in providing individual therapy and were more likely to focus on dynamic, systemic and behavioral conceptualizations, rather than biological explanations that would be treated with psychotropic medication. As the models being examined in this study are not biological and are generated from research and theory based primarily on individual therapy, these experiences may be seen as advantages. However, excluding psychiatrists limits the generalizability of the results; for instance, it is possible that different types of patients are seen by psychiatrists and that psychiatrists conceptualize delicate self-cutting differently than psychologists or social workers. Differences may include socio-economic differences in patient populations (on one hand, psychiatrists are generally more expensive; on the other, they are

more accepted by services such as Medicaid) that would affect conceptualization based on patients seen, and differences in the types of orientation of therapy (psychiatrists may be more likely to use psychotropic medications) that would also affect conceptualization.

Survey methodology often risks a response bias in that individuals who do not respond may be different than those who do. In an effort to attenuate this response bias, subjects were offered a summary of the results as incentive to participate and follow-up postcards were sent to increase response (Dillman, 1983; Moser & Kalton, 1972).

Subjects were chosen using a modified systematic random sampling procedure. Systematic random sampling is less time consuming than simple random sampling but still yields an acceptably random sample (Borden & Abbott, 1988). The *National Register* lists over 16,000 licensed psychologists alphabetically in 798 pages, with two columns per page. Systematic sampling by page entailed first determining the average number of entries per column by examining 10 randomly chosen columns. The average number of entries was 10 per column and a random number between 1 and 10 was chosen for each subject to determine the entry per column (E). Next, a random choice was made between one and two to determine the column number (C) for each subject. To determine the page numbers to be used, a random number between 1 and 48 for the first mailing (798/150=5 with a remainder of 48) or between 1 and 98 (798/100=7 with a remainder of 98) was used to choose the starting page. Subjects were the Eth entry in the Cth column on

every fifth (or seventh) page beginning on page 2 for the first mailing and page 14 for the second mailing. Random number tables were computer generated.

The *NASW Register* lists approximately 15,800 names by city and state. Thus, this listing introduces a bias of geographical area. However, registrants are also listed alphabetically in 3 columns of 81 names over 65 pages at the end of the Register. Social workers were therefore chosen by choosing a random number between 1 and 81 for the entry number for each NASW subject. For the first group of NASW subjects, a random number between one and 45 was then chosen to determine the starting column (3 x 65=195, 195/150=1 with a remainder of 45); subjects were the Eth entry in the next 150 columns starting from column 27. For the second group of subjects, a random number between 1 and 95 (195/100=1 with a remainder of 95) was chosen; subjects were the Eth entry in the next 100 columns starting from column 42. In all groups of subjects from both sources, if any subject chosen did not provide individual treatment or did not treat adolescents as well as adults, then the next listed subject was chosen. In addition, in the second mailing, if any subject had been previously chosen, the next listed subject was chosen.

Instruments and Procedures

Data consisted of answers to a survey questionnaire. The survey was printed double-sided on white paper and accompanied by an instruction page and a cover letter (see Appendices D and E). The format of the questionnaire and cover letter was informed by the work of Bordon and Abbott (1988); Dillman (1983); and

Sheatsley (1982). The survey was totally de-identified; there was no coded number corresponding to the particular subject. This was done as it was believed that therapists would be more willing to complete the survey if it were obviously confidential. Therapists were asked to focus upon their memory of a specific female patient aged 13 to 25 who engaged in more than one instance of delicate self-cutting and whom the therapist had seen in individual therapy for a minimum of five sessions. Reference patients were restricted to adolescents or young adults and females, as the literature states that most delicate self-cutters are adolescent and female. Males who engage in delicate self-cutting may present with an atypical functional and etiological picture (Clendenin & Murphy, 1971; Graff & Mallin, 1967). Similarly, delicate self cutters who began cutting at an older age may also present with an atypical clinical pattern (Pattison & Kahan, 1983) or may be more likely to reflect a chronic pattern of delicate self-cutting. Furthermore, the models being evaluated in this study were developed primarily from literature that focused on female adolescents or young adults. The standard of five sessions was used as it was felt that it would be difficult for a therapist to have enough knowledge about and experience with the patient to be able to answer the relatively detailed questions.

Therapists who were currently seeing only one patient who fit the criteria were asked to use that patient for their reference patient. Therapists who were currently seeing more than one patient who fit the criteria were asked to choose the one whose last name began with the letter alphabetically closest to A. Therapists who were not currently seeing a patient who fit the criteria but who had seen one

or more of these individuals in the past were asked to refer to the most recently terminated case. There are several reasons behind these instructions. Therapists were asked to reference a specific person rather than give their general opinion because their general opinion--which is composed of their many clinical experiences as well as any reading they have done on delicate self-cutting, on psychopathology and on personality formation--may be more likely to be confounded by the therapist's general orientation and personal opinions and experiences than is their understanding of a particular case. Focusing on one particular person may also aid accuracy of recall, as opposed to trying to remember and integrate information about several patients. The alphabetical and most recent choice criteria were used to avoid bias. If therapists had been instructed to refer to a patient of their choice, they may have chosen the most "interesting," the most "successful," or the patient who best fit their conceptualization of the "typical": cutter; these individuals may not be truly representative of the population of delicate self-cutters. In addition, using the most recent case likely increased accuracy of recall as the more temporally distant an event is, the more likely it is that recall will be distorted; this distortion can be a major problem with survey studies (Moser & Kalton, 1972).

The population of delicate self cutters being sampled likely contained some bias compared to the overall population of delicate self-cutters. Only those patients seen by a psychologist or social worker were included. This may have biased the sample in terms of socio-economic status (i.e. more money is usually needed in order to afford seeing a therapist), degree of pathology (i.e. more pathological

patients may be in therapy; there may exist less pathological delicate self-cutters who have never been in therapy), or cultural background (e.g. some cultural backgrounds, such as Japanese-Americans, may influence an individual or family to be more reluctant to turn to a therapist with problems). Thus, generalizing these results to delicate self-cutters not seen in outpatient therapy should be done with caution.

Survey questions included demographic information on the therapists (e.g. degree, orientation, gender), demographic information about the referent patient they used to complete the survey (e.g. diagnosis, age while cutting, age at treatment, number of cutting incidents), questions asking about the therapists' conceptualization of the behavior including the functional hypotheses and summary models, and some exploratory questions addressing issues such as perceived patient developmental conflicts.

The main rationale for using a survey methodology is that surveys are one of the most time and cost efficient ways to obtain data from a wide sample (Moser & Kalton, 1972; Sheatsley, 1982; Dillman, 1983). As this is a descriptive study, obtaining a relatively large nationwide sample was important. Furthermore, surveys are the method of choice when answers require consideration, rather than an immediate reply, or when a record review would make answers more accurate (Moser & Kalton, 1972). In addition, certain characteristics of the proposed sample suggested that a survey would be effective. Therapists are a relatively sophisticated and educated population, which leads to a better ability to comprehend difficult or complex questions and a greater likelihood of response (Moser &

Kalton, 19872; Sheatsley, 1982). While surveys do not enable follow-up questions or clarification, they are an appropriate and efficient methodology when using straightforward questions to test specific hypotheses, as opposed to more fluid questions investigating the context or depth of an issue.

Experimental Protocol

Subjects received an initial mailing consisting of a cover letter, a survey, a first-class stamped envelope addressed to the experimenter for return of the completed survey and a stamped response postcard coded with the subject's number (see Appendices D, E and F). The response postcard was stamped in order to enable it to be returned separately from the completed survey to ensure confidentiality. The cover letter stated the affiliation and educational purpose of the researcher (University of Massachusetts at Amherst dissertation research) and described the general purpose of the study. The letter also presented information about confidentiality and informed consent, described the purpose of the response card and defined delicate self-cutting and selection criteria for reference patients as discussed above. The coded response postcard included the following information: whether or not the subject completed the survey, the reason why he or she did not complete the survey if this was the case, and whether or not the subject wished to receive a summary of the results of the study. While the survey was de-identified for confidentiality reasons, the response postcard was coded in order to track the responses and to create a mailing list of prospective recipients of the summary. Subjects were asked to

complete and return the response postcard regardless of whether they completed the survey. Return of the response postcard removed the subject from the follow-up mailing list.

Three weeks following the initial mailing, a postcard reminder (see Appendix G) was sent to those subjects who had not returned the initial response postcard.

CHAPTER IV

RESULTS

Respondents and Referent Patients

Of the initial 500 mailed packets, 34 were returned from the post office due to the expiration of a forwarding order; this left 466 possible subjects. Of these, 316 subjects responded in some way to the mailing, yielding a response rate of 68% (see Table 5). Two hundred and sixty-four subjects returned a response card indicating they had not completed the survey. The majority of these (156 or 49%) indicated that they had never seen a delicate self-cutter. An

Table 5: Number and Percentage of Responses

	Respondents (N=316)	% of total respondents
Response Type		
Positive (Complete survey returned)	44	14%
Negative (Negative response card)	264	84%
Negative (Incomplete survey returned)	8	2%
Types of Negative Response Cards	**Respondents (n=264)**	**% of negative response cards**
Never seen a delicate self-cutter	156	59%
Delicate self-cutter didn't fit other criteria	84	32%
Delicate self-cutter seen too long ago	13	5%
No time/chose not to complete survey	11	4%

additional thirty-two percent (84) indicated that they had seen a delicate self-cutter but that he or she had not met the other selection criteria (age, gender or minimum number of sessions). Nine percent (24) of subjects chose not to complete the survey; thirteen of these subjects indicated that they had seen a patient who fit the criteria but too long ago for them to be able to recall (13).

Fifty-two completed surveys were returned, 44 of which were acceptable for data analysis. Of the remaining eight surveys, five were incomplete in answering the functional hypotheses or model summaries, making them ineligible for use in evaluating the models. The remaining three surveys described patients whose age was not within the specified range or who had not been seen for at least five sessions.

The majority of respondents were women, of a dynamic or eclectic orientation, and had been practicing for over 10 years when they first saw the referent patient. Respondents consisted of 17 men and 25 women[2]. Forty-eight percent of respondents (21) held a Ph.D., thirty-nine percent (19) held a MSW, nine percent (4) held a Psy.D., two percent (1) held an Ed.D., and two percent (1) stated they had a degree other than those above. The referent patient was most commonly seen in a private practice (77.3%; n=34) or a community mental health center (11.4%; n=5). The mean number of years in practice at the time the target patient was seen was 14.08; 10% (4) of respondents had been practicing for less than five years, 12.5% (5) had been practicing for five to ten years, 30% (12) for ten to fifteen years, 25% (10) for fifteen to twenty years and 22.5% (9) for twenty

[2]Information on gender was not provided by two subjects.

or more years[3]. The mean number of years that had passed since seeing the target patient was 2.46; 18% of respondents were currently seeing the target patient, 34% had terminated with the patient within the last year, and 14% had terminated with the patient one to two years earlier.[4] The fact that two-thirds of respondents had seen the patient within the past two years suggests a greater confidence in the findings (Moser & Kalton, 1972) as the more recently a therapist has seen a patient the more likely their memory will be reliable.

A detailed analysis of therapists' orientations is presented in Table 6 (p. 55). Respondents were of three major categories of orientation: analytical or dynamic (34%, n=15), cognitive-behavioral (20.5%, n=9) and eclectic (45.5%, n=20). Therapists who endorsed analytic, dynamic, any of the dynamic subcategories or any combination of only these categories were considered analytic/dynamic. Therapists who endorsed only cognitive-behavioral or only cognitive-behavioral and behavioral (no subject endorsed only behavioral) were considered cognitive-behavioral. Therapists who endorsed eclectic and then chose one of more of the other categories, or therapists who chose two or more orientations that were not subcategories of others (e.g. choosing behavioral and systemic or gestalt and cognitive-behavioral) were considered eclectic.

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[3]Information on length of time practicing was not provided by four subjects.
[4]Information on time passed was not provided by five subjects.

Table 6: Orientations of Respondents

ORIENTATIONS OF NON-ECLECTIC THERAPISTS (28)†			PRIMARY FOUNDATIONS OF ECLECTIC THERAPISTS (16)		
Orientation	**N**	**%T††**	**Foundations**	**N**	**% E**
Dynamic	13	50%	Dynamic	9	56%
Object-Relations	6	14%	Object-Relations	4	25%
Ego Psychology	4	9%	Ego Psychology	3	19%
Rogerian	2	5%	Gestalt	2	13%
Self Psychology	2	5%	Rogerian	2	13%
Existential	1	2%	Other Dynamic	1	6%
Other Dynamic	1	2%	Existential	0	0%
Gestalt	0	0%	Self Psychology	0	0%
Eclectic	16	36%			
Cognitive-Behavioral	11	25%	Cognitive-Behavioral	6	38%
Analytical	5	11%	Other	2	13%
Behavioral	2	5%	Systemic	1	6%
Systemic	2	5%	Analytical	0	0%
Other	1	2%	Behavioral	0	0%

†In this table, eclectic refers only to those subjects who explicitly stated that they considered themselves eclectic.

††%T refers to the percent of the total subjects; %E refers to the percent of the total number of subjects who endorsed Eclectic as their primary orientation. Both percentages will add to more than 100 since some subjects endorsed more than one orientation or foundation.

A series of oneway ANOVAs evaluated the possible influence orientation might have had on functional model endorsement (see Table 7, p. 56). The Modified Least Significant Difference method

Table 7: Model x Orientation ANOVAs

Model†	F Ratio	F Prob
SexMod x Orientation	.3178	.7295
ConMod x Orientation	1.7216	.1915
SuiMod x Orientation	2.7363	.0767
DepMod x Orientation	.2760	.7602
BouMod x Orientation	1.9539	.1547
SysMod x Orientation	.6527	.5260
ExpMod x Orientation	4.7352	.0141*
BehMod x Orientation	1.8726	.1666

†Model names are presented with model coding abbreviations (e.g. Sex, Con)--as presented in Appendix A--followed by Mod, meaning model.
*Significant at the .05 level

was used to control for the effects of multiple comparisons. Tests for homogeneity of variance (Cochran's C, Bartlett-Box F) indicated sufficient equivalence of variance. Results indicated that there was little systematic group difference. Orientation did have some effect on ratings on the expression model, with significant differences between eclectic and dynamic therapists. However, the systematic differences that would have indicated a systematic confound (e.g. behavioral therapists endorsing the behavioral model, dynamic therapists endorsing the dynamic models) were not found. There was, however, a large group of eclectic therapists. While this may be representative of the general population of therapists with the current move toward integration, it is not as meaningful in terms of being able to examine possible orientation-specific bias. Thus, it is

possible that the large number of eclectic therapists obscured possible bias due to orientation. It should also be noted that the sample was limited to those therapists providing individual therapy, thus excluding family therapists and the likelihood of endorsing a strictly systemic orientation.

Therapy with the respondent lasted from 3 months to over 16 years and from 6 sessions to over 1000, with a mean of 2.6 years and 117 sessions.[5] This figure underestimates the actual length of treatment as 18% of respondents were currently treating the referent patient. Therapy was generally seen as quite related to the cutting behavior: 88% of respondents reported that the cutting behavior and associated underlying issues were a focus of therapy and no respondent reported that the behavior was never addressed in therapy[6]. Similarly, 93.2% of respondents felt that their understanding of the patient's reasons for cutting affected the treatment. Respondents were not as clear about the success of the therapy. When asked to rate the success on a scale of 1 (not at all successful) to 6 (very successful), 42.9% (n=18) of respondents rated the therapy only partially successful (a 4 rating), although only 7.2% (n=3) rated the therapy as not successful (1,2 or 3 rating).[7] In contrast, respondents were much clearer about the specific effects of therapy on cutting with 95.1% stating that therapy had contributed to the patient's stopping or decreasing cutting.[8]

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[5]Information on total time in therapy was not provided by one subject.
[6]Information on whether cutting was a focus of therapy was not provided by two subjects.
[7]Information on success of therapy was not provided by two subjects.
[8]Information on the effect of therapy on cutting was not provided by three subjects.

The mean age of the referent patient when first seen was 17.5 years. The mean age that referent patients began delicate self-cutting was 15.26 years with a range from 8 years to 24 years (SD=3.0 years)[9]; only one patient started cutting prior to age 12. This finding supports previous research which found the age at first cut to vary between 13.5 (Favazza & Conterio, 1988) and 23.9 (Gardner & Gardner, 1975).

Patients cut for an average of 3.59 years, ranging from one month to 20 years (SD=4.08 years)[10]. Most (73%) patients engaged in at least five incidents of cutting, emphasizing the repetitive nature of the behavior: 43% engaged in more than 15 instances of cutting, 30% engaged in five to fourteen instances of cutting and only 27% cut one to four times. Thirty-one (70%) patients had stopped cutting. The mean age that patients stopped cutting was 18.84 years, with a range from 13 years to 37 years (SD = 5.04 years).[11]

Slightly more than one third (16) of patients were hospitalized during treatment with the respondent and 42% (n=18) received additional treatment while in therapy with the respondent[12]: 3 subjects received additional individual therapy, 9 subjects received adjunctive family therapy, 8 subjects participated in group therapy and 5 subjects received some other type of additional therapy. Half the patients were taking psychotropic medication at some time during their therapy with the respondent[13]. Forty-four percent were

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[9]Information on age at first cut was not provided by one subject.
[10]Information on length of time cut was not provided by four subjects.
[11]Information on age at last cut was not provided by eight subjects.
[12]Information on additional treatment was not provided by one subject.
[13]Information on medications was not provided by one subject.

on anti-depressants, nine percent were on anti-psychotics, 5 percent were on minor tranquilizers and 14 percent were on anti-anxiety medications. Almost half the patients had a prior history of psychiatric hospitalization (46%, n=20) and more than half (61%; n=27) had received some type of treatment prior to beginning therapy with the respondent. Half the patients had received previous individual therapy, about one third (31%; n=14) had received previous family therapy, and 11% (5) had received previous group therapy.

Patients were given a wide variety of diagnoses (see Table 8).

Table 8: Referent Patients' Diagnoses

Axis I Diagnosis	n	%	Axis II Diagnosis	n	%
Depression (Major)	17	38.6%	Borderline PD	28	63.6%
Adjustment Disorder	16	36.3%	No Axis II Diagnosis	6	13.6%
Dysthymia	11	25.0%	Dependent PD	5	11.4%
Substance Abuse	6	13.6%	Narcissistic PD	3	6.8%
Bulimia	5	11.4%	Avoidant PD	2	4.5%
Anorexia	4	9.1%	Histrionic PD	2	4.5%
Generalized Anxiety	4	9.1%	Obsessive-Compulsive	2	4.5%
Multiple Personality	4	9.1%	Passive Aggressive	2	4.5%
Other	4	9.1%	Antisocial PD	1	2.3%
Bipolar Disorder	2	4.5%	Other	1	2.3%
Cyclothymia	2	4.5%			
Obsessive-Compulsive	2	4.5%			
No Axis I Diagnosis	1	2.3%			

The most common Axis I diagnoses were major depression (38.6%) and adjustment disorder (36.3%). The most common Axis II diagnosis was borderline personality disorder (63.6%). Seventy percent of respondents indicated that symptoms other than cutting were the major determinants of the diagnosis.

Model Evaluation and Relationships Between Models

It was hypothesized that the many reasons suggested in the literature to address why patients self-mutilate could be organized into eight separate and distinguishable models, integrating different theoretical perspectives. Each model was composed of some number of reasons in the literature that reflected the same basic functional theme. Only hypotheses that were shown by the pretest to conceptually reflect the theme of the model and differentiate that model from others were used in the final model make-up. Whether these models truly existed in the real world, and to what extent therapists used them in their understanding and treatment of patients were addressed by the main study.

Evaluation of the models required not only that the functional statements group together as expected (termed here coherence) but also that the groupings are associated with the underlying concept with which they were united (conceptual unity). Results of the factor analysis (see Table 9, p. 61) indicate that the hypotheses do group together in accordance with the hypothesized Boundaries, Sexual, Systemic, Depersonalization, Expression and Suicide models. Examination of the initial correlation matrix of functional hypotheses, the initial communality of each hypothesis and the anti-image

Table 9: Initial Factor Analysis

	FAC 1	FAC 2	FAC 3	FAC 4	FAC 5	FAC 6	FAC 7	FAC 8
BOU4	**.74804**	.10778	.04240	.09022	.38855	.07920	.00759	-.08100
BOU3	**.65964**	.19540	.16443	.25785	-.03559	-.10537	-.07751	.55694
BOU2	**.65469**	.29494	.18557	.21527	.34726	.18366	-.03202	.04375
BOU1	**.64950**	.15058	.22818	.22940	.17033	.08374	.13440	-.08839
CON2	**.61444**	-.07362	.10379	.00266	-.02252	-.00368	.07068	.12257
SEX5	**.39662**	.32326	-.04700	-.03373	.05262	.10416	.04351	.11872
SEX3	-.05506	**.77175**	.09473	.16204	.03289	.13526	-.02916	.10134
SEX1	.27686	**.74511**	.15191	-.13346	-.06344	-.24306	.02952	-.12165
SEX2	.43617	**.69764**	-.12500	.01311	.03236	.20843	.02935	-.01002
CON3	.21329	**.57413**	.17747	.20674	.17527	.23729	.30462	.11508
CON1	.28844	.13320	**.88793**	.01023	-.02217	.07991	-.05874	.04087
EXP2	.22365	.07248	**.85599**	.02826	-.15409	-.13317	.08707	.08353
SYS2	.17448	.09917	-.03252	**.79087**	.07069	.06244	.00174	.00605
BEH1	.24906	-.01695	.00472	**.68634**	-.11907	.22802	.05620	-.06548
SYS1	-.01100	.17062	.31641	**.48147**	.04985	.13523	.25974	.35609
DEP2	.43347	.10060	-.07220	-.11664	**.82169**	-.06931	-.01088	.05340
DEP1	.22042	.01727	-.10640	.05369	**.76954**	-.01751	.05520	-.04781
BEH2	.18280	.08010	-.01795	.11498	-.08240	**.86807**	.03353	.18570
SEX4	.14916	.19697	-.01805	.24536	.02796	**.61661**	.01672	-.10702
EXP3	.31145	.18379	.05292	.12786	.08799	.01655	**.84231**	.24386
EXP1	.54418	-.00693	-.02375	.04709	-.04881	.04741	**.56207**	-.08817
SUI1	.41097	.07421	.10995	-.07634	-.03113	.13345	.22413	**.69430**

correlation matrix indicated enough relationship between variables to enable a factor analysis. Bartlett's test of sphericity yielded a value of 524.051 with a significance level less than .00000, enabling rejection of the hypothesis that the variables are collinear. The Kaiser-Meyer-Olkin measure of sampling adequacy yielded a value of .6168, an adequate if not optimal value. Sampling adequacy measures for each individual variable yielded similar values. Although only seven factors had an initial eigenvalue of over 1.0, examination of the eigenvalue graph suggested that inclusion of the eighth factor (with an eigenvalue of .986) would yield the most accurate grouping of significant factors, accounting for almost 80% of the total variance. In addition, as the predicted grouping of hypotheses would yield one factor with only one hypothesis (the Suicide model), there was a theoretical reason for including a factor with a variance approximately equal to one. The unweighted least squares extraction method was used to extract the eight factors. This method was chosen as it minimizes the difference between observed and reproduced correlation matrices and yielded the best goodness of fit as reflected in the residuals; only 7% of residuals were greater than .05 with this method, compared with 24% in a principal components analysis. A quartimax rotation was applied to the resulting factors. This type of rotation minimizes the number of factors needed to explain a variable; this is in contrast to the more traditional varimax method which minimizes the number of variables with high loadings on the extracted factors.

Alpha coefficients further supported coherence for the Boundaries, Sexual, Systemic, Depersonalization, Expression and

Suicide models, with these six models having alpha coefficients greater than .5 (see Table 10).

Table 10: Alpha Coefficients of Functional Hypotheses†

Model (mean)	Alpha	Hypth. name	Mean of item	Corr.	Alpha - item
Sex	.7120	Sex1	1.6818	.5325	.6377
(1.7318)		Sex2	1.6364	.7290	.5665
		Sex3	2.5455	.5602	.6648
		Sex4	1.3636	.2641	.7292
		Sex5	1.4318	.4111	.6914
Behav	.4871	Beh1	2.9773	.3220	
(2.5341)		Beh2	2.0909	.3220	
Express	.5901	Exp1	4.8182	.5017	.3384
(4.7121)		Exp2	4.8636	.1975	.7629
		Exp3	4.4545	.5370	.2595
Control	.4411	Con1	4.5000	.4102	.1186
(3.9091)		Con2	4.1364	.2153	.4452
		Con3	3.0909	.2064	.4639
System	.5381	Sys1	4.6364	.3736	
(3.8977)		Sys2	3.1591	.3736	
Depers.	.8544	Dep1	3.9318	.7480	
(3.5795)		Dep2	3.2273	.7480	
Bound.	.8507	Bou1	2.5682	.7054	.8083
(2.5682)		Bou2	2.5455	.7789	.7710
		Bou3	2.5455	.5836	.8541
		Bou4	2.6136	.7139	.8019

†See Appendix 1 for text corresponding to coding of hypothesis name (e.g. sex1).
Mean of item = mean of model hypotheses.
Correl. = Pearson correlation coefficient between score on specific hypothesis and sum of scores on other hypotheses.
Alpha - item = alpha if specific hypothesis deleted

Conceptual unity was supported for all models by the correlation of group means and models (see Table 11, p. 64). Group

Table 11: Correlations of Models and Group Means†

	Con Mean	Sui Mean	Dep Mean	Bou Mean	Sys Mean	Exp Mean	Beh Mean	Sex Mean
Con Mod	**.5084****	.2537	.1218	.3862*	.3553*	.5440**	.2823	.1980
Sui Mod	.4524*	**.6057****	.1234	.4195*	.2708	.5029**	.3052	.1643
Dep Mod	.2461	.0419	**.7460****	.3982*	-.0405	.0971	-.0197	-.0048
Bou Mod	.5265**	.3978*	.4725**	**.6710****	.1640	.3626*	.1950	.2005
Sys Mod	.4517*	.3051	.1199	.5663**	**.6192****	.4143*	.6295**	.4413*
Exp Mod	.3907*	.0990	.0017	.2252	.2915	**.5294****	.2694	.0485
Beh Mod	.1558	.1149	.1162	.4029*	.6206**	.1045	**.6211****	.0282
Sex Mod	.4648**	.2909	.2241	.4442*	.2996	.2724	.2697	**.7521****

†N of cases: 44 1-tailed Signif: * - .01 ** - .001

means were computed by averaging across the functional hypotheses in a given hypothesized grouping (e.g. SexMean=mean of Sex1, Sex2, Sex3, Sex4 and Sex5). All models showed significant correlations as predicted with some models relating to other group means as well. The group means of the control, expression and boundaries models are notable for being significantly related to most of the other model summaries.

Forced multiple regressions and stepwise regressions, while considerably less reliable because of the substantial possibility of Type I errors due to the number of analyses run (72) provide secondary support for conceptual unity (see Tables 12 and 13, pages 65 and 66). Forced regressions, using the eight groupings of

Table 12: Regressions of Grouped Functional Hypotheses on Summary Models†

	Sexmod	Behmod	Expmod	Conmod	Sysmod	Depmod	Boumod	Suimod
Sex	.70362***	-.04830	-.08708	.012752	.26082	-.00214	.09998	-.00221
Beh	.08109	.64524***	.02833	.03501	.35579***	-.03295	-.00460	.09415
Exp	.07233	-.04887	.25008*	.25092*	.14576	-.04672	.09855	.25097*
Con	.26955*	.00270	.14760	.22187*	.17868	-.00016	.26803*	.19375*
Sys	.06258	.47455***	.05031	.19276*	.35645***	-.00166	-.01036	.04536
Deper	.00818	-.03389	.00128	-.03262	-.01783	.53500***	.18544*	-.02050
Bou	.19367	.11820	.06477	.22052*	.33191**	.15504	.43597***	.28323*
Sui	.06285	-.01030	-.01377	.04208	.07146	-.02201	.13822*	.35179***

†Adjusted R-Square is presented; F significance: *-.01, **-.001, ***-.0001

Table 13: Stepwise Regressions†

	Sexmod	Behmod	Expmod	Conmod	Sysmod	Depmod	Boumod	Suimod
Variables	Sex2	Beh1	Exp2	Sys1	Bou2	Dep2	Bou4	Sui1
entered	Sex5	Sys2	Exp3	Bou1	Sys2	Dep1	Con3	Con1
	Sex3	Sex3			Beh2		Sex3	
		Bou3						
Adjusted R^2	.64798***	.75888***	.24834**	.32578***	.55262***	.53500***	.56246***	.45897***

†F significance: *-.01, **-.001, ***-.0001

functional statements with each of the eight models, support that functional statements are significantly related to the expected summary models, although they may also be related to other summary models as well. A histogram of Studentized residuals and a normal probability plot showed no violations of normality.

In order to further illuminate the complex interactions between functional models, a correlation matrix of the models was created (see Table 14).

Table 14: Correlation Matrix of Models

	SEX MOD	CON MOD	SUI MOD	DEP MOD	BOU MOD	SYS MOD	EXP MOD	BEH MOD
SEX MOD	1.0000							
CON MOD	.2006	1.0000						
SUI MOD	.2487	.4943**	1.0000					
DEP MOD	.1144	.0538	.1895	1.0000				
BOU MOD	.2801	.2670	.3973*	.6014**	1.0000			
SYS MOD	.4040*	.2525	.2767	.0599	.3236	1.0000		
EXP MOD	.2701	.3963*	.4339*	.2226	.1810	.3838*	1.0000	
BEH MOD	.1387	.1841	.2418	.1931	.2445	.4404*	.1816	1.0000

N of cases: 44, 1-tailed Signif: * - .01 ** - .001

It appears that many of the models are significantly related. The expression model and the systemic model in particular appear to be related to many of the other hypothesized models.

The eight functional models initially presented are clearly related in a variety of ways as demonstrated by the mixed picture presented by the stepwise regressions and the many correlations demonstrated between hypotheses, group means and models. Higher order factor analyses attempted to examine the possible underlying relationships in a quantitative fashion. Two analyses were performed, one using the group means (see Table 15) and another using the previously obtained factors (see Table 16, p. 69). It was

Table 15: Higher Factors Using Means

	Fac1	Fac2	Fac3
ExpMean	.82916	.15678	.08864
SuiMean	.79752	.05688	.02082
ConMean	.73752	.32610	.32223
BehMean	,14454	.85055	-.06505
SysMean	.13896	.81826	.10335
SexMean	.25334	.42907	.42239
DepMean	.01520	-.10073	.91723
BouMean	.54066	.34564	.63381

Table 16: Higher Factors Using Prior Factors

	Fac1	Fac2	Fac3
Fac3Mean	.91123	.05537	-.02863
Fac7Mean	.90487	.10970	.10425
Fac8Mean	.37574	.37212	.32385
Fac6Mean	-.07409	.85212	-.01483
Fac4Mean	.16135	.71215	.01710
Fac2Mean	.23382	.50215	.34158
Fac5Mean	-.10417	-.07700	.92600
Fac1Mean	.46160	.38993	.67135

hoped that the results of these analyses would coincide, lending credence not only to the higher factors generated but also to the initial factors generated, as their grouping would suggest a parallel concept to that reflected in the group means. The two analyses did support each other, each yielding three factors. Bartlett's test of sphericity enabled rejection of the collinear hypothesis for both analyses. The Kaiser-Meyer-Olkin measure of sampling adequacy indicated sufficient relationships between variables, as suggested by the correlation matrix of models above. Results of the principle components analysis using means initially yielded only two factors with an eigenvalue over 1. However, as in the initial factor analysis, examination of the eigenvalue plot suggested an additional factor. In

addition, using three factors enabled comparison with the higher order factor analysis using previous factors, which yielded three factors with eigenvalues over 1. The three factor principal components analysis of means with a varimax rotation indicated that the expression, suicide and control models are highly related. The behavior, systemic and sexual models create the next factor, followed by the depersonalization and boundary models. Results of the principle components analysis using previous factors with a varimax rotation show similar results. The previous two factors containing expression and suicide statements and the factor that was both control and expression statements created one higher factor accounting for the most variance. The second higher factor consisted of the previous factors containing primarily systemic and sexual statements and one prior factor that was mixed behavioral and sexual statements. The third higher factor consisted of previous factors that had contained primarily depersonalization and boundary statements.

A correlation between reasons for stopping and functional models (see Table 17, p. 71), supported relationships between models. With the exception of the boundary and expression models, all models are significantly related to the associated reasons for stopping, suggesting that therapists' understanding and treatment approaches are significantly related.[14] However, this correlation also indicates unpredicted relationships between models.

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[14]Information on reason for stopping was not provided by six subjects.

Table 17: Correlations of Models with Reasons for Stopping†

	Stop Sex	Stop Con	Stop Sui	Stop Dep	Stop Bou	Stop Sys	Stop Exp	Stop Beh
Sex Mod	**.7573****	-.0375	.0404	.0313	.2095	.1218	-.0653	.2200
Con Mod	.0300	**.4108***	.2904	-.0240	.0926	.3001	.2567	.1408
Sui Mod	-.0188	.0890	**.5341****	.0775	-.0405	.1040	-.0170	.2215
Dep Mod	-.0724	-.1398	.0205	**.5284****	.1300	-.0810	-.1938	.2176
Bou Mod	-.0670	-.1611	-.0409	.1438	**.1605**	.2394	-.1565	.3541
Sys Mod	.2930	.1893	.2669	-.1036	.3421	**.6051****	.0738	.2732
Exp Mod	.2193	.1099	.1694	.0957	.1401	.0648	**-.1157**	-.0787
Beh Mod	.2009	.2638	.2054	.1133	.1165	.4486*	.0982	**.6253****

†N of cases: 38, 1-tailed Signif: * - .01 ** - .001

Model Endorsement

The most highly endorsed individual hypotheses explaining the function of cutting were: "Her cutting is an expression of intense anger at abandonment, where the anger is redirected inwards because she feels that to direct the anger outwards could destroy the other person or the relationship"; "She experiences her intense affect as being out of control. Her cutting is an attempt to control her affect into something concrete and specific"; "Her cutting expresses the anger and conflict of the family or environment that is not expressed in a more direct manner"; "Her cutting is an expression of overwhelming affect that is experienced as so intense she feels it cannot be contained"; and "Her cutting is an expression of

overwhelming anger and need that is seen as invalid. Cutting translates the feeling into an external injury which validates and expresses the emotion." Three of these hypotheses were from the expression model. The least highly endorsed hypotheses were: "Her cutting stems from an ambivalent desire to destroy the genitals in order to avoid acting on sexual feelings that are seen as threatening"; "Her cutting is an attempt at controlled penetration as opposed to penetration imposed from outside (i.e. intercourse)"; "She observed that other cutters achieve relief from emotional pain. She imitated this behavior and continued it when she achieved the same relief"; "Her cutting is a result of a negative reaction to menarche where bleeding is exposed and controlled rather than hidden and involuntary"; and "Her cutting is a masturbation equivalent, offering sexual gratification." Four of these hypotheses were from the sexual model.

The expression and control model summaries received the most endorsement (see Table 18, p. 73). The depersonalization and boundaries models were also highly endorsed, with over 60% of therapists rating these models as relevant to understanding their referent patient's cutting behavior (a 4 or higher rating). The sexual model was the least highly endorsed model: none of the respondents indicated that it was the major underlying dynamic and 50% said that it did not apply to the patient at all. The suicide model also received little endorsment, with fewer than 15% rating it as highly related to cutting.

Ratings on reasons for stopping reflected similar endorsement (see Table 19, p. 73), with most respondents relating stopping or

Table 18: Ratings of Models†

Model	1	2	3	4	5	6
Expression model	4.5%	11.4%	4.5%	15.9%	34.1%	29.5%
Control model	6.8%	4.5%	9.1%	15.9%	40.9%	22.7%
Depersonalization model	18.2%	11.4%	9.1%	27.3%	18.2%	15.9%
Boundaries model	15.9%	2.3%	30.5%	18.2%	29.5%	13.6%
Systemic model	29.5%	18.2%	4.5%	20.5%	20.5%	6.8%
Behavioral model	38.6%	13.6%	13.6%	11.4%	18.2%	4.5%
Suicide model	22.7%	29.5%	18.2%	18.2%	11.4%	0.0%
Sexual model	50%	25%	9.1%	11.4%	4.5%	0.0%

† Scale ratings range from 1 (does not apply to this person at all) to 6 (applies to this person very well, this is the major dynamic behind the cutting behavior).

Table 19: Ratings of Reasons for Stopping†

Reasons for Stopping† †	1**	2	3	4	5	6
Expression issues	0.0%	2.4%	9.8%	12.2%	46.3%	29.3%
Control issue	5.1%	10.3%	7.7%	10.3%	41.0%	25.6%
Boundaries issues	12.2%	4.9%	14.6%	17.1%	39.0%	12.2%
Systemic issues	22.0%	7.3%	9.8%	19.5%	29.3%	12.2%
Depers. issues	19.5%	17.1%	12.2%	19.5%	19.5%	12.2%
Behavioral issues	31.6%	7.9%	7.9%	21.1%	23.7%	7.9%
Suicide issues	22.0%	29.3%	17.1%	9.8%	17.1%	4.9%
Sexual issues	51.2%	17.1%	9.8%	19.5%	2.4%	0.0%

†Scale ratings range from 1 (not at all a reason for stopping cutting for this person) to 6 (one of the major reasons this person stopped cutting behavior).

†† Resolution of Expression issues, Resolution of Control issues, etc.

decreasing cutting to the resolution of issues concerning expression and control of affect and boundaries.[15] The sexual model again received the least endorsement as none of the respondents indicated that resolution of sexual issues was a major reason for stopping cutting and over 50% indicated that it was irrelevant.

Almost 40% of respondents stated that other cutters they had seen cut for very similar reasons (a 5 or 6 on a scale where 1 = not at all the same reasons and 6 = practically identical reasons).[16] An additional 47% indicated some commonality of reasons (a 4 rating).

Developmental Issues

The developmental issues explored also varied in the amount of endorsement received (see Table 20, p. 75). It can be seen that the most relevant developmental issues are related to identity formation and individuation.

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[15]Information on resolution of expression, systemic, suicide, depersonalization, sexual and boundaries issues was not provided by three subjects; information on resolution of control issues was not provided by five subjects; information on resolution of behavioral issues was not provided by six subjects.

[16]Information on similar reasons was not provided by six subjects.

Table 20: Ratings of Related Developmental Issues†

Developmental Issue	1-2	3-4	5-6
Achieving a clear sense of what is self and what is not, including the ability to distance from others' emotions[17]	20.9%	27.9%	51.2%
Separating from parents[17]	30.2%	20.9%	48.8%
Establishing identity[17]	30.2%	23.3%	46.5%
Resolution of aggressive feelings toward mother[17]	14.0%	39.5%	46.5%
Achieving internal ability to soothe and forgive	29.5%	25.0%	45.5%
Establishing independence and self-motivation[17]	39.5%	16.3%	44.2%
Integrating good and bad within the self and others[17]	25.6%	34.9%	39.5%
Achieving a sense that others will continue to care over time, even if separated or angry[17]	30.2%	34.9%	34.9%
Differentiation from mother[17]	27.9%	37.2%	34.9%
Resolution of sexual feelings toward father[18]	47.6%	19.1%	33.3%
Achieving internal sense of self-acceptance[17]	38.1%	33.3%	28.6%
Resolving the sense that one is responsible for all occurrences and others' emotions[17]	44.2%	27.9%	27.9%
Achieving a sense of self consistent across situations[18]	52.4%	23.8%	23.8%
Resolving the desire to become a part of another[17]	48.8%	27.9%	23.3%
Achieving an internal conscience that is realistic and has the capacity to forgive[17]	37.2%	39.5%	23.3%
Dealing with the physical changes of puberty[17]	62.8%	18.6%	18.6%
Achieving ability to use symbols to express oneself, including the use of abstract language[17]	48.8%	34.9%	16.3%
Achieving a sense of something to strive toward in terms of self, i.e. an internal ideal[18]	47.6%	38.1%	14.3%

† Scale ratings range from 1 (this issue is not at all connected to cutting) to 6 (this issue is very much connected to cutting).

[17] Information on this developmental issue was not provided by one subject.
[18] Information on this developmental issue was not provided by two subjects.

CHAPTER V
DISCUSSION

Previous research and clinical observation generated a significant amount of information describing self-mutilating patients, but there was little agreement on the reasons for the behavior. Walsh and Rosen (1988) advocated research on this topic: "Investigators should not abandon the difficult, complex area of assessing intent. It remains crucial to understand *why* individuals self-mutilate--that is, what they intend through this behavior" (p. 37). This study attempted to address the "why" by evaluating eight models that were created from the reasons put forth in the literature to explain why patients engaged in delicate self-cutting. The results suggest several issues that focus on (a) the patient population, (b) the structure of the models, (c) the implications of the models and the structure as reflected in the results upon the function and meaning of delicate self-cutting, (d) implications for effective treatment and (f) directions for future research.

The Patient Population

Of the total 316 respondents, 47% (149) had seen a delicate self-cutter at some time during their practice. This suggests that understanding this behavior, the psychopathology that underlies it, and the treatment strategies used to treat it effectively would be important for clinicians, as they have almost a one in two chance of seeing one of these patients.

The responses also suggest that there may be a greater number of delicate self cutters (64%) who do not fit the traditional picture. Eighty-seven respondents indicated that they had seen a delicate self-cutter but that the patient did not fit the inclusion criteria for this study. This means that the patient was either (a) male, (b) not between the ages of 13 and 25, (c) not seen in individual therapy, or (d) seen for fewer than 5 sessions. While the structure of the questionnaire does not permit definitive analysis of this group, at least some portion of these patients were excluded because they failed to meet the gender or age criteria. This supports the contention that a delicate self-cutting syndrome, defined solely by patient demographics, does not exist. While wrist cutting may be distinguishable from other types of self-mutilating behaviors, the traditional age and gender limitations may not encompass the majority of individuals who engage in this behavior. This study focused on female adolescents, as the majority of previous literature suggested that this was the most relevant population and the functional hypotheses used to create the models tested were taken from literature focusing primarily on this population. However, the choice to limit the population and the finding that many cutters exist who do not fit this criteria limits the generalizability of this study. Future studies would do well to expand inclusion criteria in terms of gender and age and would benefit from examining possible differences in function and meaning of the behavior between traditionally "atypical" cutters (e.g. males and those that begin cutting in childhood or after adolescence) and those cutters who fit the traditional demographic picture.

While the limitations on the population sampled may limit the generalizability of these results, therapists' responses indicate that respondents have great confidence in the generalizability of their own understanding. Eighty-seven percent of therapists stated that other cutters they had seen engaged in cutting for similar reasons as their referent patients. While this may be reflecting therapists' own tendencies to use similar conceptualizations for similar presenting problems, it may also lend credence to the idea that cutters are a relatively homogeneous group in terms of intent, if not demographics.

The diagnoses assigned to the referent patients in this study were generally consistent with those discussed in the literature. There were, however, more referent patients with a diagnosis of adjustment disorder than one might predict, suggesting that cutting may be related to temporary stressors and difficulties. There has been little investigation of the relationship between amount and types of current stressors (other than perceived interpersonal loss) in the literature. Future research could benefit from investigating the current life stressors of patients who engage in this behavior and the ways in which these life stressors contribute to cutting.

Although 70% of respondents stated that cutting was not the major diagnostic contributor, 88% of therapists said that the therapy focused on cutting and the reasons underlying cutting and 93% stated that their understanding of the functions of cutting significantly affected the therapy. Furthermore, these data show that, at least from the therapists' points of view, therapy is significantly contributing to decreasing or stopping cutting, although therapists

were less convinced that the therapy as a whole was as successful. This pattern suggests that therapists are focusing on cutting and underlying issues in therapy and having good success at ameliorating the symptoms they are addressing. If diagnosis is to be meaningful in terms of treatment planning and evaluation, perhaps the diagnosis of deliberate self harm proposed by Kahan and Pattison (1984) is a good idea. In addition, the data concerning age of first and last cut suggests that this behavior may be developmentally related, suggesting a further distinguishing characteristic that would aid in diagnosis and appropriate treatment planning. Finally, a deliberate self harm diagnosis would help differentiate the behavior from suicide attempts, which is supported by this data where 84% of respondents stated that the cutting was not a suicide attempt.

The Possibility of a New Structure

In spite of the small sample size, which would work against obtaining a stable factor structure with clearly defined factors, six of the eight models--the expression, depersonalization, boundaries, systemic, sexual and suicide models--showed coherence and conceptual unity. The factor analysis and generation of alpha coefficients failed to show coherence for the behavioral and control models. The lack of coherence likely contributes to the muddier picture of conceptual unity for these models as well. While the small number of subjects and the post-hoc analysis make it impossible to know why the behavioral and control hypotheses did not group together into differentiable models, some hypotheses may be

generated by examining the pattern of coherence and conceptual associations and re-examining the literature for support.

The most plausible hypothesis to explain the lack of clear differentiation for the behavioral model is that the relationship consistently shown between the behavioral model and the systemic models is making it impossible to differentiate these two models. It is possible that the behavioral functions and the systemic functions represent the same underlying function. In the factor analysis, while one behavioral hypothesis is largely separated from the other models, the other behavioral hypothesis is grouped within the systemic factor. In terms of conceptual validation, the behavioral hypotheses show an even stronger relationship to the systemic model; the group mean of the behavioral hypotheses is significantly correlated with the systemic model and behavioral hypotheses significantly regress onto the systemic model. Finally, the behavioral model summary shows a significant relationship with the systemic model summary, suggesting that the underlying, unifying concepts of the models are significantly related. Thus, it would seem that a reasonable hypothesis to account for the lack of a behavioral factor is that the behavioral model as described here is a part of the systemic model, and cannot be clearly differentiated from it in actual use (as opposed to conceptually as in the pretest).

A re-examination of the literature supports the hypothesis that the concepts within the behavioral model are quite related to the systemic model. If reinforcement and secondary gain come primarily from the family or interpersonal system with which the individual is involved, the difference between system dynamics and

behavioral patterns becomes blurred. While studies showing that cutting results in increased attention and social status suggest that there may be a current reinforcement pattern for the behavior (Offer & Barglow, 1960; Favazza, 1989; Podovoll, 1979), the suggestion that the behavioral model begins in the family context of childhood with learned patterns of associating injury and care (Simpson and Porter, 1981) links the behavioral model even more strongly to traditional systems theories. The original model conceptualization saw the systemic model leading to cutting as the cutter interacted with the system and served the system through cutting. The behavioral model was seen as distinguishable in its greater emphasis on present reinforcement. However, the lack of differentiation between the two models in these results underscores the difficulty of attempting to examine behavior and reinforcement patterns independently of the larger contextual issues. Perhaps the behavioral hypotheses are the flip side of the systemic coin; both focus on the interaction between cutting and environment, one examines how the interaction between cutting and cutter serves the system and the other examines how the interaction between cutting and system serves the cutter. This possibility is reflected in Podovoll's (1979) systemic understanding. He recognizes the admiration and envy the action can produce, focusing on how these responses indicate that the cutting is serving a systemic need. While these responses are a direct reinforcement in the behavioral model, it is possible that the true meaning of them to the cutter is the evidence that she is valued by the system rather than the core meaning being the behavioral process through which cutting is adopted as a coping mechanism. Thus, the literature would

support investigation into a general environmental model (encompassing both the systemic and behavioral hypotheses) suggested by the present data.

The control model is the second model that failed to show sufficient differentiable coherence in the factor analysis or the generation of alpha coefficients. However, unlike the behavioral hypotheses, the control hypotheses do not seem to be consistently related primarily to one other model. The factor analysis shows that two of the control hypotheses are part of the boundary and sexual models, respectively. The one control hypothesis that, with an expression hypothesis, is a part of one of the ambiguous factors is con1 (cutting serves to control excessive affect by channeling it into something concrete). The alpha coefficient for the control grouping indicates that it is this hypothesis that is the most important in uniting the three control hypotheses. Perhaps the control model is a valid, differentiable model defined primarily by this concept, while the other hypotheses, while related to the control theme, are also significantly related to other models and do not functionally differentiate between them. While this is one hypothesis, the picture is further complicated by the fact that the control hypotheses as a group are significantly related to most of the other models as demonstrated in the correlation of models and group means where the control mean was significantly related to the suicide, boundaries, expression and sexual models; and the forced regressions where control hypotheses were significantly related to the sexual, boundary and suicide models. One possible explanation is that control, like anger, is an issue underlying many of the other models. If this was

true then one would not only expect the control hypotheses to relate to other models but also expect the control model summary to relate to other model summaries or hypotheses. If control were an underlying issue, it would be the unifying theme as reflected in the individual hypotheses that would be underlying other models, not just the specific and more detailed hypotheses themselves. These expected relationships are evident in the data: the control model is significantly related to boundaries, systemic and expression hypotheses in the correlation of models and group means; the control model is significantly related to the expression and suicide models in the correlation matrix of model summaries; the control model is significantly related to expression, systemic and boundaries hypotheses in forced regression; and the stepwise regression for the control model consists of systemic and boundaries hypotheses. The only model or group of hypotheses that does not significantly relate to the control model in some way is the depersonalization model.

The data suggesting that control is a theme underlying the other models may imply a different way of approaching the models. Perhaps control is a way to deal with the basic affect and the other models are concerned with the interpretations or intrapsychic issues related to that affect. If this were the case, one might also expect the expression model to be an underlying model dealing with the affect, rather than specific meaning assigned to that affect. The data suggests that this may be a possibility, although the results are not as strong as for the control model. While the expression model demonstrates coherence and conceptual unity, it is also significantly related to many other models. The expression hypotheses were

significantly related to control, suicide, boundaries and systemic models in the correlations of models and group means; and the expression model was significantly correlated with control and suicide models in the correlation of model summaries. This pattern suggests that the expression model may be related to many of the other models, but is able to be clearly differentiated. Furthermore, the consistent strong relationships shown between the expression and the control models suggests that they may be on the same level or related to the same issues. These relationships are evident in the correlation of models and group means, the forced regression onto the control model, the correlation matrix of models and the results of the pretest. The higher order factors also lend support for the connection between the expression and control models. The expression, control, suicide factor may be united in its emphasis on the internal recognition and regulation of affect, with the expression model emphasizing the need to display affect and the control model emphasizing the need to contain it. The suicide model may be related if it is seen as a particular type of expression (or as avoiding a particular type of expression).

The pattern of relationships between the expression model and other models is also supported by the functional literature which agrees that cutting often serves to release tension or express anger or anxiety, whether its source is the system, the loss of personal boundaries, the interpersonal loss of an individual or the threat of expressing sexual urges (e. g. Doctors, 1981; Ettinger, 1992; Favazza & Conterio, 1988; Novotny, 1972; Schwartz et al., 1989; Simpson & Porter, 1981). Thus, expression is clearly a major dynamic and may

be a significant contributor to the function of delicate self-cutting even when other, more detailed functions are present.

If control and expression are seen as concepts underlying the other models, a different structure begins to emerge. Whereas the structure originally contained eight models on the same level, the new structure has two underlying models and six others (or five if one wants to accept the collapse of the behavioral and systemic models into one). Whereas it was previously expected that cutters would choose one of the eight as the primary function, the new structure assumes that all cutters struggle with control and expression of affect and that the other six models are more differentiated and specific to individual cutters. In terms of the higher factors generated here, the new structure would suggest that the expression/control/suicide factor would be a foundation upon which the other models or other factors rested.

Pine's (1990, 1992) integration of the four basic psychodynamic theories is a useful way in which to understand how control and expression may be underlying concepts related to the other proposed functional models. Pine (1992) uses a metaphor of a well to examine the relationships between the four psychologies, stating that in the bottom of the well (the mind) are drives, object concepts, or subjective states of self depending on whether one adheres to a drive, object relations or self psychology theory. He goes on to describe the place of ego psychology:

> ego psychology is...*the plumbing*. It has to do with how the contents of the well are held down or brought to the surface, how they are deflected en route to the surface, or

> how altered during that route--all aspects of what is done with the well's contents. In this sense, an ego psychology is relevant to all of the 'deep contents' of the well--drives, object relations, and states of self." (Pine, 1992, p. 5)

The content of the well's depths are (a) the sexual model; (b) the systemic and behavioral models; and (c) the depersonalization and boundaries models. These contents are respectively rooted in (a) psychoanalytic drive theory, (b) realistically based object relations theory (as opposed to internal objects) and (c) object relations and self psychology theory concerned with internalized objects and the development of a separate identity. The control model and, to a lesser extent, the expression model, are rooted in the ego, in ego psychology, Pine's "plumbing." The concepts underlying the control model are concerned with containing the effects of the conflicts engendered by the other models, the sexual and aggressive urges, and the need for connection and boundaries. Thus, it is related to all other models to a greater or lesser extent. The expression model is the other function of this plumbing: the contents of the well must not only be channeled but they must be released, the pipes cannot simply be stopped up, as the water (the different contents of the well) will continue to build up. The purpose of the plumbing is to channel the release, not to arrest it.

Given that the expression and control models are reflecting the underlying plumbing of the system and are dealing with the basic function of affective regulation that is common to all human beings, one would expect that these models would be the most highly endorsed, as they are relevant regardless of the specific meaning

assigned to the preceding loss. This was indeed the case: the expression and control models were the most highly endorsed of all the models.

The Function and Meaning of Delicate Self-Cutting

This new structure described above may be reflecting the difference between the function (embodied in the control/expression level) and the meaning (embodied in the other models) of cutting. Function would be the self-expressed, conscious intent, reflecting the basic adaptive nature of the behavior and fulfilling basic needs such as affect regulation and maintenance of ego that are experienced as necessary by all people. Meaning may or may not be conscious and able to be expressed (Arnkoff, 1980; Mahoney & Gabriel, 1987); it is more likely than function to be related to unconscious motivations and needs. Meaning is also more likely to be explicitly tied to specific developmental experiences and the resulting world view (Arnkoff, 1980; Mahoney & Gabriel, 1987; Santostefano, 1988) than is function, which reflects basic needs. Finally, meaning informs us more about why a particular behavior is chosen to be adaptive (Santostefano, 1988), for example, why cutting as opposed to some other behavior; what are the specific aspects of cutting that combine to make cutting more desirable than other types of behavior? Using Pine's metaphor, the meaning is determined by the contents of the well, while the function is the plumbing which deals with the expression or containment of the affect generated by all contents. While the function may not be able to be changed (i.e. everyone needs to regulate affect so that it is not overwhelming and

threatening basic ego integration), the meaning and the way in which the function is fulfilled can be changed (Arnkoff, 1980). Changing the meaning of the preceding event and the meaning of the cutting itself would lead to different, more adaptive choices of behaviors for fulfilling the function.

This approach, separating function and meaning into two levels, is congruent with the data generated here. The new structure suggested by the generation of higher order factors and the many relationships between the expression and control models and the other models would be predicted by the differentiation between function and meaning that is described above. In addition, as the data shows, one would expect the functional models (expression and control) to be most highly endorsed, and perhaps more difficult to differentiate from the many meaning models, because they are relevant regardless of the meaning assigned. One would also expect therapy to address the function of the behavior in its attempt to understand the meaning and to find new behaviors that could fill that function. This expectation was shown in the data, as therapists most highly endorsed the resolution of expression and control issues. In fact, more therapists endorsed the resolution of expression issues as reasons for stopping or decreasing cutting than endorsed the expression model as a reason for cutting. This finding suggests that therapists who are explaining the cutting with other models are addressing expression issues in treatment, perhaps because they are also embedded within the other models.

The function of cutting is thus to regulate affect through a balance between control and expression. More therapists are using

these functional models to understand cutting than any of the meaning models proposed. This focus is consistent with the many authors who have focused on the need to express or control the intense affect. Anna Freud's (1958) connection between self-mutilation and defensive reversal of affect emphasizes the need for control and expression of affect. Reversal of affect is a defense against the adolescent's overwhelming need and desire for merger; the adolescent changes the love into hate and the dependency into revolt (Freud, 1958). However, the hostility which defends against the need for the love object soon becomes intolerable to the ego and defended against by projection outward onto the parents, or "conversely, the full hostility and aggression may be turned away from the objects and employed inwardly against the self. In these cases, the adolescents display intense depression, tendencies of self abasement and self injury, and develop, or even carry out, suicidal wishes" (Freud, 1958, p. 321). Other authors agree that turning the aggression inwards is one way to control or defend against it while the depression or self-injury is a simultaneous expression of it (Doctors, 1981; Friedman et al., 1972; Miller & Bashkin, 1974; Woods, 1988). Friedman et al. (1972) propose that internalization of the aggression is a means by which to manage the aggression without destroying the object. They further explain the ways in which simultaneous expression and control is achieved: one function of the self-mutilation is to control and channel the aggression by "destroying the body, regarded by the adolescent as the instrument through which actual expression can be given to the wish to kill the mother" and the second function is to express the affect by "turning

the feeling of helplessness in the face of the aggressive and sexual urges into one of omnipotence (echoing their frequent use of turning passive into active)" (Friedman et al., 1972, p. 181). Pao, working from an ego psychology stance (Pine's plumbing orientation) also makes explicit the connection between expression and control. She states:

> ...the tenseness led the patient to give up an ego-directed interaction with the external environment by becoming self-engrossed, auto-erotic and totally unrelated to contemporary objects and to enter a regressed ego state with surrendering of autonomous ego functioning to a drive-dominated act which was simultaneously sadistic and masochistic. (p. 198)

Pao (1969) simultaneously emphasizes that subsystems are established in the ego which maintain certain ego functions, such as motor control. Self-mutilators have been unsuccessful in their attempts to create or maintain an autonomous ego in the face of strong anxiety and interpersonal conflicts. Cutting reestablishes the power of the ego functioning through regression to a state where the drives can be expressed while also serving to control them by maintaining some ego control and enabling a return to an autonomous ego state.

The control and expressive functions of cutting are also consistent with the one depth study that investigated how cutters themselves saw the function of their behavior. According to the theory presented above, when asked about the reasons behind their behavior, self-mutilators would be most likely to discuss the functions of the behavior, as opposed to the meaning assigned to it

which may be more unconscious. Ettinger's interview study of 10 women who engaged in deliberate self harm (8 delicate self cutters) provides support for the expression and control models as she found that transforming emotional pain into physical pain and releasing overwhelming emotions were the two most frequently described reasons for self-mutilation. Her analysis enables a closer examination of the possible meaning of expression. She states that transforming emotional pain was connected to "the satisfaction at being able to see, and sometimes feel, the cut or bruise as they were injuring; the importance of having a lasting, albeit often short-lived, physical testament to their inner feelings; and, the significance of being able to show someone else, advertently or inadvertently, the enormity of their pain" (Ettinger, 1992, p. 74). Her second reason, releasing overwhelming feelings, is also a core concept of the expression model. This reason encompasses the concept that the emotion cannot be contained; one subject stated that she felt: "there is so much going on all at the same time it is almost impossible to function. And, I've just got to release somehow" (Ettinger, 1992, p. 79). This study also supports the connection between control and expression as Ettinger discussed how expressing or externalizing pain was a way to control it: "as these women articulated, they do not feel any control over the enormity of their internal pain, they at least feel some control over their external self-injury" (p. 77). The agreement between what therapists are using to understand their patients--as reflected in the results of this study--and how patients understand their own behavior--as demonstrated by Ettinger's (1992) work--is heartening as it suggests that therapists' views are reflecting the

actual experience of patients as opposed to the therapists' own experiences or theoretical biases.

If the two-tiered theory suggested by the data here is correct then self-mutilating patients will likely have both functional and meaning reasons for cutting. While the function of cutting is embodied in the expression and control models, the remaining models (depersonalization, boundaries, systemic, behavior, suicide and sexual) are the key to understanding the meaning assignments that led to cutting as the behavior of choice. The internal question is: what behavior is best at dealing with these intense emotions? For these patients, the meaning assigned to cutting makes it the most adaptive behavior. The remaining six models attempt to tease out the meaning assigned to cutting.

The data presented in this study indicate that the depersonalization and boundaries models are the most highly endorsed specific models; all other models were endorsed by less than 50% of respondents (receiving a 3 or less on a scale of 1 to 6 where 1 = does not apply to this person at all and 6 = applies to this person very well, this is the major dynamic behind the cutting behavior). These models may be seen to be strongly related to each other in the correlations of models and group means, the forced regression onto the boundaries model summary, and the correlation matrix of models. These two models also formed the second higher order factor, perhaps unified by their emphasis on creating and maintaining a sense of self. The depersonalization model is concerned primarily with creating and maintaining the sense of self in the face of internal dissolution while the boundaries model

emphasizes maintaining boundaries between the self and other and dealing with the desire for and threat of merger. The connection is made explicit by Waltzer (1968): "In the depersonalized state, there is an inability to maintain a whole, or completely integrated, ego-responsiveness to environmental or intrapsychic stimuli. The ego has lost control over the integrity of its functions or over the accurate representation of body-image boundaries and the sense of reality" (p. 401). The high (and almost equal) endorsement of these two models suggests that the most common meaning assigned to the behavior is the reintegration of self, whether in response to a dissolution from depersonalization or a dissolution from the threat of merger.

If the boundary and depersonalization models are thought to be the meaning behind the cutting then these models should demonstrate why cutting in particular is the behavior of choice for dealing with the intense affect precipitated by the perceived interpersonal loss that is generally noted in the phenomenological and observed accounts of self-mutilation. Anna Freud (1958) states that the task of adolescence is differentiation from the mother and the pathologies of adolescence are related to the inability to break the ties with infantile love objects; self-mutilation is one type of adolescent pathology stemming from the defensive maneuvers adopted to deal with this inability. Other authors agree that the perceived interpersonal loss leads to such intense, primitive affect because the patient has been unable to differentiate self from other or to establish an independent cohesive sense of self (Doctors, 1981; Miller & Bashkin, 1974; Walsh & Rosen, 1988; Woods, 1988).

Walsh and Rosen (1988) state that self-mutilating adolescents experienced loss or abandonment during the early narcissistic or object love phase of development, resulting in an incapacity for self or object love. The threat or actual loss in the present reactivates the profound anguish associated with the childhood experience, leading to an unbearable tension stemming not only from the early narcissistic injury but also from the lack of individuation to which that loss led (Walsh & Rosen, 1988). Thus, the fear of abandonment is relived in the present and cannot be mediated by a separated, fully individuated ego. The inability to verbalize the feeling is also a result of the failed developmental process, as the development of communicative, rather than evocative symbols depends on the successful development of cohesive self and other objects (Doctors, 1981; Sarnoff, 1988; Walsh & Rosen, 1988). This inability leads to the need for an action-based expression of affect.

Friedman et al. (1972) also hypothesize that self-mutilation is rooted in the reaction to detachment from the original love object of the mother. Their mutilating adolescents had extremely ambivalent relationships with their mothers, characterized by hostile and loving feelings co-existing. Hostility was viewed by these authors as a defense against regressive, passive, homosexual wishes in relation to the mother who was seen as a powerful, active person threatening to overwhelm the adolescent identity (Friedman et al., 1972). All of their patients also had a current constant fear of abandonment, accompanied by a struggle against emotional involvement with others.

Thus, the literature suggests that the meaning assigned to the loss is self-dissolution and fear of the identity being overwhelmed by affect. This meaning is likely rooted in developmental issues and experiences that led to difficulty differentiating self from other and difficulty creating an observing ego based on a consistent sense of self that would enable better affect management. The hypothesized meaning assigned to the perceived interpersonal loss is supported by these results indicating that therapists believe that these patients are struggling with developmental issues that center on issues of separation, individuation and identity development: achieving a clear sense of self, separating from parents, establishing identity, resolving aggressive feelings towards mother, achieving an ability to self-soothe and establishing independence and self-motivation.

This meaning assignment necessitates a behavior that would affirm self-identity either in the face of the loss of an object with whom the patient was merged, in the face of intense affect that threatens to engulf the ego, or in the face of numbness that was initially a defense against this affect but now threatens the reemergence of the self. Cutting appears to be a behavior of choice as it reaffirms the most basic boundary of the flesh, the first boundary that contributes to a sense of self (Raine, 1982; Simpson, 1980). Raine (1982) sees the skin in terms of object relations development: the skin is the simplest body boundary and in early stages the relationship with the world and the mother is mediated through the skin. Simpson (1980) discusses using the body as a transitional object and summarizes the issues these patients are dealing with:

> Their preoccupation is with the unfinished business of establishing their body image and with problems of limits--of the body itself, of their own power and competence and their aggression and capacity for feeling and suffering. They seek achievement of a unitary self, contained within the limiting membrane of the skin, with an inside and an outside and a reliable distinction between self and not-self. (p. 275)

The lack of a unitary self comes from the early experiences reviewed above; cutting is especially good at defining that unitary self as it differentiates the self on the most basic level of the physical embodiment: the skin. Cutting also creates a specific identity "I am a cutter" (Podovoll, 1969; Raine, 1982; Simpson, 1980) and provides a transitional object (blood) that is contained within the body and is therefore always present and that belongs uniquely to the cutter Doctors, 1981; Kafka, 1969; Simpson, 1980; Woods, 1988. Cutting is also a direct, concrete act, a far more primitive symbolic representation of the anguish than any verbal representation could be. Cutting may be the behavior of choice because of the combination of ways in which it meets the various aspects of creating boundaries.

In contrast to the high endorsement of the depersonalization and boundaries models, the sexual model received very little endorsement, suggesting that therapists did not see sexual issues as relevant to the meaning behind cutting. These results were somewhat surprising, given the amount of literature addressing delicate self-cutting from a psychoanalytic, psychosexual developmental point of view. The results of this study suggest that it

may be more fruitful and relevant to explore other intrapsychic issues, specifically those of identity formation and maintenance and separation/individuation issues in order to understand the meaning of this behavior.

The suicide model was also not endorsed very highly. It appears that most therapists do not see the primary function of cutting as avoiding suicide. Eighty-four percent of respondents also denied that the cutting behavior was related to a suicide attempt. The results indicating that cutting is neither a suicide substitute or a suicide attempt support the distinction made in the literature between these behaviors. While these two behaviors certainly have common ground in terms of some underlying dynamics and common characteristics of patients engaging in them, and future research might attempt to determine the aspects of function or meaning that the two behaviors have in common, these results suggest that delicate self-cutting can and should be operationally differentiated from suicide (in terms of lethality, repetition, intent and function) when attempting to understand the underlying dynamics or treatment strategies for either behavior.

The only moderate amount of endorsement for the systemic model is somewhat surprising, given the high endorsement of family-related developmental issues. This would suggest that systemic or family variables are seen as most relevant in the intrapsychic effects that they create. Thus, it is the way in which the object relations were internalized, rather than the relations themselves, which is most important in understanding the function of delicate self-cutting. However, it should be noted that these

results are biased towards the individual as this study focused on the conceptualizations of therapists who were seeing delicate self cutters in individual, rather than family, therapy.

Treatment Implications: Changing the Meaning

The importance of understanding the meaning of the behavior and its developmental antecedents lies in the ability to apply this understanding to developing effective treatment. While the function--the need to modulate emotion--will remain, the meaning assigned to the preceding event, to the cutting or to other possible behaviors, can be changed resulting in a decrease of the symptoms and an increase in overall mental health. The results of this study indicate that therapists believe that resolution of issues relating to expression, control and boundaries models are the major reasons for stopping or decreasing cutting. Specifically, the results indicate that:

1. Her cutting stopped or decreased due to a greater acceptance of her own needs and emotions and learning to express her feelings verbally or through other less destructive means (75.6% highly endorsed).

2. Her cutting stopped or decreased due to learning other ways to control her emotions or interactions with others and learning that intense emotions cannot destroy her (66.6% highly endorsed).

3. Her cutting stopped or decreased due to the development of clearer boundaries and learning alternative ways to affirm her sense of self (51.2% highly endorsed).

Resolution of issues related to expression and control is focused on changing the meaning assignment to other behaviors so that they

serve this function better than self-mutilation, as well as changing the meaning assigned to the emotions so that the affect is not so overwhelming. Resolution of issues related to boundaries is focused more on changing the meaning that the affect is associated with, the meaning assigned to the perceived interpersonal loss and associated with the developmental experiences focusing on separation/ individuation and the development of identity. The literature agrees that these themes are the most relevant in terms of planning effective treatment with these patients. Discussions of psychodynamic treatment generally focus on two themes: increasing the self-mutilators ability to verbalize and express emotion and addressing the difficulties of self-object individuation and merger through creating a positive object experience (Bennum & Phil, 1983; Ettinger, 1992; Feldman, 1988; Graff and Mallin, 1967; Podovoll, 1969; Raine, 1982; Simpson, 1980; Woods, 1988).

The treatment literature on self-mutilation supports the need to address expression and control of affect in order to decrease or eliminate the cutting behavior. Nelson and Grunebaum (1971), in their unique treatment outcome study, found that the most common reasons given for improvement included: a) an increased ability to cope with feelings, especially sexual and angry feelings, b) increased verbal expression of feelings, c) learning to use more constructive means to channel their impulses and d) control of psychotic delusions. The first three of these reasons are directly relevant to the expression and control models as presented here. Other authors agree that one of the most therapeutically relevant dynamics of the self-mutilator is her difficulty verbalizing emotions and needs and

that therapy should therefore focus on developing the ability to articulate emotions and needs and learning to use alternative behaviors to communicate and channel feelings and create an environmental response (Bennum & Phil, 1983; Feldman, 1988; Graff and Mallin, 1967; Podovoll, 1969; Simpson, 1980).

The literature also suggests that addressing boundaries issues, specifically through the relationship and process of therapy is most important. Feldman (1988) states that a dependent but collaborative relationship often develops and cautions the therapist against an overconcern with rescuing the patient, suggesting that the therapist be aware of the tendency towards merger. Raine (1982) emphasizes the need for the therapist to put him or herself forward as an object experience:

> One aim of a psychotherapeutic relationship is to enter this closed circle to help the patient see the triggers, the interpersonal factors that bring the cutting episode about within the relationship and then to offer oneself as an object for projection, instead of the self-self cycle. (p. 11)

Woods (1988) sees the therapist as an extension of the patient, due to the self-mutilators insufficient sense of self and lack of boundaries. He cautions that self-mutilators may attempt to engage the therapist in the same torturer-victim pattern they have experienced in their other relationships and in their relationship to themselves. In addition, he theorizes that the therapist will need to become the transitional object for the self-mutilator, supplanting the patient's own body in this function and providing a real relationship in which the patient can begin to define and differentiate herself in

relation to others, thus progressing from merger through separation/ individuation. He notes that this can be a difficult experience for the therapist as well as the patient:

> To give up the illusion of symbiotic union "with a primitive love object," the patient must first have the opportunity to re-create it or something like it in relationship to the therapist. The anxiety that both patient and therapist will be lost inside the shell of such a symbiotic fantasy is one that needs to be constantly acknowledged and processed. (p. 52)

This anxiety is one piece of the strong countertransference that is discussed in the literature. The difficulty expressing and controlling affect, combined with the lack of boundaries in these patients may be the primary reasons why therapists experience such strong countertransferential feelings (Favazza, 1989; Feldman, 1988; Leibenluft et al., 1987; Menninger, 1938; Pao, 1969; Woods, 1988). Pao (1969) reflects that therapists had the most difficulty with the self-mutilators' rapid regression to self centered, "object unrelated" states, reinforcing the idea that therapists are struggling with the threat of merger.

The narcissism of these patients may also contribute to the countertransference. This narcissism is evident in these data in the most common Axis II diagnoses assigned to the referent patients: borderline, dependent and narcissistic personality disorders. Podovoll (1969) points out that these patients see their behavior as isolated, "an act of supreme isolation and loneliness" (p. 213). The patients are oblivious to the independent existence and reactions of others. They see their acts as affecting only themselves:

> That such a complex series of events is quite 'open', that it involves the people lived with at every point, that it evokes feelings of unbearable intensity in those involved in care, that it challenges the roles of individual staff members and the structure of the hospital as a whole--these remain, for long periods of time, perceptions and recognitions beyond the scope of functioning. (Podovoll, 1969, p. 214)

Kernberg (1988), Miller and Bashkin (1974), Novotny (1972) and Walsh and Rosen (1988) agree that self-mutilators have had disruptions in the very early stages of psychosexual and object relations development leading to the development of narcissistic personality traits. Thus, relations with others are not viewed in terms of a separate object that is unified and independent. This narcissistic stance may be a further contributor to therapists' countertransferential reactions.

Leibenluft, Gardner and Cowdry (1987) state:

> Our experience leads us to believe that professionals are prone to attribute hostile or manipulative intent to the behavior and that they pay insufficient attention to the internal experience of the patient, both cognitive and affective. (p. 323)

This may be because the intense desire for merger and the lack of individuation of the patients threatens the therapist and the therapist reacts by defending him or herself through distancing and blaming. The knowledge that these patients are struggling with boundaries issues and experiencing difficulty with symbolic, verbal expression of affect that is reflected in the literature and in these

results may help therapists be aware of their own countertransference and thus be more helpful to these patients.

The difficult countertransferential issues suggested by the literature may be part of the reason behind the difficulty treating these patients suggested in these data. The results of this study addressing the treatment history of the referent patients indicates the difficulty in treating these patients: 61% had received previous treatment, 46% had a prior history of hospitalization, 41% were hospitalized while in treatment with the respondent and the therapy with the respondent lasted an average of 2.6 years and 117 sessions. Repeated attempts at treatment, especially at such a young age (13-25) and the length of the treatment that is significantly higher than the average length of psychotherapy (Garfield, 1986) may suggest early psychological difficulties that were either relatively intractable to treatment or extensive enough to require repeated, long-term therapeutic interventions. However, these results may also be related to the difficulty therapists experience with these patients that is discussed in the literature and supported by these data as described above.

Looking Towards the Future

Future research is needed to test the new structure that consists of: (a) a functional foundation consisting of control and expression models and dealing with the regulation of emotion that is relevant regardless of the other models endorsed, and (b) 5 models addressing meaning: boundaries, depersonalization, sexual, suicide and a general "environmental influences" model collapsing the

present behavioral and systemic models. In addition, the models that were supported here could also be further refined. The results of the alpha coefficients generated here suggest that some concepts are more central within the models than are others. Differentiating these concepts and constructing models that are more centered upon these core concepts would be useful in refining our understanding of meaning and potentially our ability to change meaning through therapy. Evaluating the models and the new structure not only in therapists' conceptualizations but also in patients' experience would be most important. It is vital that patients' experience be reflected in these models and not just therapists' theories and opinions. The little data available on self-mutilators self-reports of the meaning and function of the behavior is consistent with the models most highly endorsed by therapists: Ettinger's (1992) study found that expression and control of overwhelming feelings and pain, and ego reintegration were the most frequently described functions in her sample. The new methods of content analysis may be useful in examining interviews and therapy interactions to uncover the meaning and function of self-cutting as it is experienced by the patients themselves. Using patients who have stopped cutting may also be useful, as they may have a perspective and an ability to step back and examine their experiences that patients who are still in the midst of the experience lack.

The differential endorsement of the models in this study suggest that, at least with this population, future research should focus primarily on the expression, control, boundaries and depersonalization models. The sexual and suicide models, while

reflecting important themes and traditional concepts, appeared far less useful to therapists who were attempting to understand the patient's experience and need to engage in this behavior. We are just beginning to understand the issues of merger and separation/ individuation with which these patients are struggling and this study has barely begun an investigation into the developmental experiences that may contribute to these issues. Because issues of boundaries and self-representation appear so central in these patients, an examination of the early attachment experiences and present attachment styles of these individuals may help us in understanding their basic world views. In addition, prior research indicating the increased likelihood that these patients suffered from abuse in childhood would suggest that much could be gained by integrating findings in that area with understanding the meaning of interpersonal loss and the reaction of self-mutilation. In general, it would be useful to focus future research on the meaning of cutting, that is the meaning assignment to cutting and the interpersonal loss that parallel each other and make cutting in particular the coping strategy of choice. This focus will help narrow our approach and will likely contribute to an understanding of the unique aspects of the underlying pathology that may differentiate these patients from others.

Research on the process of therapy with these patients and treatment outcome would also be helpful. Prior research suggests that dynamic group therapy with self-mutilators may help diffuse some of the transferential and countertransferential issues that can be so difficult in individual therapy, as well as provide a forum for

the development of trust in interpersonal relationships (Feldman, 1988; Grunebaum & Klerman, 1967). Grunebaum and Klerman (1967) also advocate for family involvement, an approach which would appear to make sense, given the dysfunctional family backgrounds seen in most self-mutilators. However, there is little empirical evidence for the efficacy of these interventions or for the ways in which they may be effective alone or as an adjunct to individual psychotherapy. How the issues of boundaries and depersonalization indicated in this study interact with a group or family process is also unknown.

There is also a need for additional information about treatment strategy and outcome in individual therapy. Most of the information on treatment has been from small, inpatient populations, yet Favazza and Conterio's (1988) study suggests that outpatient therapy may have a higher success rate, at least from the patient's point of view. More information is needed about the factors that contributed to the cessation of self-mutilation and the therapeutic techniques and focus (both content and process) that were most effective in helping these adolescents change the meaning they assign to events. Recent research on the ways in which the therapeutic relationship helps create change may be especially relevant with these patients, as this study and others suggest that interpersonal issues are central to their pathology. Ettinger's patients' advice to clinicians was "to be willing to talk about the self-injury, to be nonjudgmental, to know the difference between self-injury and suicidality, to try to understand the function and origination of the behavior and not to 'freak out'" (p. 89). This would suggest that therapists'

understanding of the possible function and meanings of this behavior could be quite helpful to the therapeutic process and the patient's experience of being helped.

The above description of future research directions has focused on areas of research that would help us understand these patients and the meaning they assign to the preceding interpersonal loss and the resulting self-mutilation. The results of this study suggest that there are other patients who self-mutilate who do not fit the traditional demographic picture and were thus not included in this study. Once the function and meaning structure is refined as discussed above, it would be useful to use this structure to evaluate the similarities and differences between cutters who fit the traditional demographic picture and those who do not. Is the developmental and functional meaning of cutting similar for all patients who engage in the behavior or are there differentiable groups, perhaps identifiable through demographic characteristics such as age or sex, that self-mutilate for different functional or etiological reasons? The respondents in this study suggested relatively homogeneity of function but perhaps they were only using patients who fit the original referent criteria in their evaluation of homogeneity. It is possible that the meaning of cutting for the traditionally studied group of adolescent females (those used in this study) is different than that of other cutters such as males or older patients. This has been suggested by previous studies of inpatients (Clendenin & Murphy, 1971; Graff & Mallin, 1967; Pattison & Kahan, 1983). Using the refined model structure described above with a population of cutters that is not limited by gender or age would

enable comparisons between groups and an evaluation of the homogeneity of cutters in terms of meaning assignment and function. This study has attempted to move towards a greater understanding of meaning but it remains to be seen whether this meaning is applicable to all cutters or only those who fit the traditional demographic picture used here.

It may also be helpful to attempt to differentiate those individuals who stopped cutting (the majority in this study) from those who continue to self-mutilate for many years. The meaning assigned to the behavior could be quite different, and an understanding of the difference would give us valuable information about the factors involved in stopping and the way meaning assignment is changed that leads to a cessation of cutting. The data on age at starting and stopping in this study suggest that for many patients cutting may be an adolescent phenomenon. Comparing those individuals who cut only in adolescence to those who continue to cut in a chronic manner may also illuminate the role of adolescent developmental issues.

Using the refined model structure to compare self-cutters with other types of self-mutilators will help determine whether a self-cutting syndrome exists based on the meaning or function of the behavior. It is quite possible that these models may not be valid for other types of self-mutilators or that they may endorse different models than self-cutters do. It may also be helpful to attempt to place self-mutilation in a context within aggressive or destructive behaviors in general. Self-cutting is a particular type of inwardly-directed, direct, non-lethal behavior. Understanding its relationship

to other-directed violence and indirect self- or other-destructive behavior may aid our general understanding. These behaviors may be serving similar functions (e.g. control and expression of anger) but the meaning assignment leading to the choice of behavior is clearly different. There may be common aspects of meaning assignment within these behaviors, as well as meaning assignments that clearly differentiate between the behaviors and the personalities and psychopathologies of the individuals who engage in them. Understanding the meaning assignments would contribute to the development of treatment strategies that could change the meaning. In addition, the ability to predict self or other-directed violence would likely be enhanced by understanding the intrapsychic events leading up to the behavior.

The assumption has been that self-cutters experience common developmental experiences that lead to common meaning assignments to interpersonal events and possible coping strategies such as cutting. This study has constructed functional models and attempted to show that they are differentiable and that they do encompass the meaning assigned to self-cutting. The purpose of this has been to begin to identify the meaning and functions actually assigned to self-cutting, as opposed to that meaning that is most consistent with our various theories of psychopathology. The purpose of evaluating the models is to use those models to understand the function and meaning of the behavior and the precipitating events. Understanding this meaning leads to the ability to predict the meaning and the behavior that would be associated with future experiences. The sum of this understanding can be used

to plan treatment that will change the meaning of the preceding event (so that interpersonal loss is not seen as devastating), change the meaning of cutting (as an acceptable behavior and the best adaptive reaction available) and to create new meanings and new behaviors that are realistically more adaptive (e.g. viewing interpersonal loss as a survivable experience and meeting expressive, control or boundary needs through verbal expression or other non-destructive actions). Favazza and Conterio (1988) state:

> ...self-mutilation is hardly a rare behavior. The inadequate attention given to the problem by researchers may reflect the widespread societal perception that self-mutilation is a repulsive, senseless, and even frightening act. (p. 27-28)

Therapists, too may fear self-mutilation and self-mutilators and this may impede their ability to help these individuals. Though it may appear senseless, the behavior certainly has meaning to those who engage in it and this meaning reflects the meaning they assign to the preceding events. One of Ettinger's (1992) subjects emphasized her need for understanding: "It does make sense...it's not craziness. It has meaning in a crazy world." Psychologists and clinicians need to comprehend the meaning not only in order to be less frightened or repulsed, but also to enable empathy, understanding and the creation of change with these patients.

APPENDIX A

BRIEF EXPLANATION OF THE EIGHT MODELS AND TWENTY-EIGHT CODED REASONS FOR CUTTING[19]

Models and Coding

B Behavioral model: cutting begins as a result of reinforcement of destructive behavior and linking injury with care. The behavior is reinforced both by relief of negative emotions and secondary gain such as attention and social status. Changes in reinforcement as well as learning alternative ways to obtain similar reinforcements result in a decrease in cutting.

Sys Systemic model: cutting is a way to express the systemic dysfunction of the family or environment. The cutter protects the system by expressing the inexpressible and taking responsibility for it. Changes in how the family deals with conflict and the roles adopted by members result in a decrease in cutting.

Sui Suicide model: cutting is a suicide replacement or an unconscious attempt at suicide. Resolution of suicidal feelings results in a decrease in cutting.

Sex Sexual model: cutting is a result of conflicts over sexuality and menarche. Resolution of these issues results in a decrease in cutting.

Exp Expression model: cutting stems from the need to express overwhelming anger, anxiety or pain that is seen as unable to be expressed more directly. Learning alternative methods of expression and acceptance of emotions results in a decrease in cutting.

Con Control: cutting stems from a need to control affect, not just express it. Cutting helps actively control the affect or provides punishment for affect that is perceived as out of control. Learning alternative ways to control affect and understanding that intense affect is not necessarily out of control and destructive leads to a decrease in cutting.

Dep Depersonalization: cutting is a way to end or cope with the

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[19]The hypothesis number used in the main study results section is indicated to the left of each hypothesis in italics. Hypotheses without numbers were rejected on the basis of data from the pretest.

effects of depersonalization that results from the intensity of affect. Cutting ends the depersonalization through color shock, pain or some other mechanism. Marks or scars from cutting may also help to combat the disorienting effects of episodes of depersonalization. Decreasing depersonalization episodes or finding alternative ways to cope with the effects results in a decrease in cutting.

Bou Boundaries: cutting is a way to create boundaries or identity. Intense affect results in fear of being engulfed or fear of loss of identity. Cutting creates clear boundaries between self and other and contributes to a sense of self. Developing clear boundaries and identity and learning alternative ways to affirm these results in a decrease in cutting.

Functional Hypotheses

B *Beh1* Cutting results in attention or status (due to endurance of pain or risk) from others; patients cut to receive this attention or regard.

B *Beh2* Patients observe that other cutters achieve relief from emotional pain. They imitate this behavior and continue it when they achieve the same relief.

B Early family experiences link pain and care through physical abuse and forgiveness cycle. Cutting is an attempt to reenact this cycle and produce caring by producing pain.

B Cutting is an attempt to actively control others: "if you leave, I will hurt myself."

Sys *1* Cutting expresses the anger and conflict of the family or environment that is not expressed in a more direct manner.

Sys 2 The cutter cuts to focus attention on herself and deflect attention from other problems in the system (e.g. parental conflict).

Sui *1* Cutting is a suicide replacement where death is avoided by replacing it with partial destruction.

Sex *1* Cutting stems from an ambivalent desire to destroy the genitals in order to avoid acting on sexual feelings that are seen as threatening.

Sex *2* Cutting is an attempt at controlled sexual penetration as opposed to penetration imposed from outside (i.e. intercourse).

Sex *3* Cutting is punishment for sexual feelings

Sex *4* Cutting is a result of a negative reaction to menarche where the bleeding is exposed and controlled rather than hidden and involuntary.

Sex *5* Cutting is a masturbation equivalent, offering sexual gratification.

Exp *1* Cutting is an expression of affect that is experienced as so intense the patient feels it cannot be contained.

Exp *2* Cutting is an expression of intense anger at abandonment, where the anger is redirected inwards because the cutter feels that to direct anger outwards could destroy the other person or the relationship.

Exp *3* Cutting is an expression of overwhelming anger and need that is seen as invalid, cutting translates the feeling into an external injury which validates and expresses the emotion.

Con *1* Intense affect is experienced as being out of control. Cutting is an attempt to control affect by channeling it into something concrete and specific.

Con *2* Cutting creates a feeling of control as the cutter feels that she controls her own life and death

Con *3* Cutting is punishment for being out of control. Intense affect or needs are seen as out of control and perceived as potentially destructive.

Con Cutting is an attempt to control anger of another person that is directed at the cutter. The anger from others is turned into anger at self that can be controlled and will not totally destroy the self.

Con Cutting is a way to control feelings of abandonment; cutting helps the patient withdraw from others before they can withdraw from the cutter.

Con Cutting is an attempt to control the intensity of affect by turning affect into something external that can be distanced from.

Dep *1*	Perceived abandonment leads to excessive affect which leads to depersonalization. Cutting is a way to end this coping mechanism through color shock, pain or some other mechanism.
Dep *2*	Cutting is a way to assure existence during or connect periods of depersonalization. Marks or scars from cutting are concrete evidence of existence during depersonalization.
Bou *1*	Cutting establishes clear boundaries between self and other by reaffirming the basic boundary of the flesh.
Bou *2*	Cutting establishes clear boundaries between self and other by creating something that is uniquely "mine," i.e. blood.
Bou *3*	Cutting establishes clear boundaries between self and other by emphasizing the personal ability to die.
Bou *4*	Cutting creates a definite identity: "I bleed therefore I am" or "I am a cutter."
Bou	Cutting and blood proves independent existence, as it is a solitary act with concrete consequences and proof of own will.

APPENDIX B

PRETEST COVER LETTER

November 30, 1992

Dear Colleague,

I am just beginning my dissertation work on self-mutilating behavior in outpatient adolescents. I am interested in how therapists conceptualize the reasons behind the "delicate self-cutting" syndrome, where patients repeatedly make multiple, non-lethal cuts or scratches. The literature suggests that there are a variety of reasons for engaging in this behavior and I am investigating whether the conceptualizations offered in the literature coincide with the experience of therapists treating these patients.

In order to test the theoretical models proposed to explain this behavior, I need to know that the specific reasons I am using in my survey reflect the models that I have used to differentiate them. In order to do this, I need your help. Attached is a pretest, asking you to sort the specific reasons into one of eight models. I would greatly appreciate it if you could complete the questionnaire and return it to my departmental mailbox by December 15, 1992. Your responses will enable me to state with confidence that the reasons do indeed reflect the underlying models, or will indicate the need for further examination and clarification.

Please be assured that all of your responses will remain confidential; your informed consent is implied in your completion and return of the questionnaire. If you would like a summary of the results of the final study, please put a request in my departmental mailbox. If you have any questions feel free to call me at (phone number). Your time and cooperation are greatly appreciated.

Sincerely,

Karen L. Suyemoto, M.S.

APPENDIX C[20]

PRETEST

Instructions

On the following page eight models are described and a coding is shown for each model (B, Sys, Sui, Sex, Exp, Con, Dep, and Bou). The remaining pages list 28 reasons for delicate self-cutting. Please sort these 28 reasons into the eight models described, by circling the coding which represents the model that is most associated with the particular reason being classified. If you feel that the reason does not reflect any of the models provided, please classify that reason into the "other" category. The reasons do not have to be equally distributed among the models. Although the eight models and codings are briefly reviewed at the top of each page, if you come across a reason that seems difficult to code, please refer to the initial, detailed description. In addition, please note that the questionnaire is two-sided. Please return your completed questionnaire to my departmental mailbox by December 15, 1992. Your participation is greatly appreciated.

-next page-

[20]In the actual survey, questions were not numbered. The questions have been numbered here in order to enable cross-reference with the Percentage Matrix for the pretest results. In addition, the model that each functional hypothesis was theoretically associated with is presented here in italics,

Models and Coding

B **Behavioral model:** cutting begins as a result of reinforcement of destructive behavior and linking injury with care. The behavior is reinforced both by relief of negative emotions and secondary gain such as attention and social status.

Sys **Systemic model:** cutting is a way to express the systemic dysfunction of the family or environment. The cutter protects the system by expressing the inexpressible and taking responsibility for it

Sui **Suicide model:** cutting is a suicide replacement.

Sex **Sexual model:** cutting is a result of conflicts over sexuality and menarche

Exp **Expression model:** cutting stems from the need to express overwhelming anger, anxiety or pain that is seen as unable to be expressed more directly.

Con **Control:** cutting stems from a need to control affect, not just express it. Cutting helps actively control the affect or provides punishment for affect that is perceived as out of control.

Dep **Depersonalization:** cutting is a way to end or cope with the effects of depersonalization that results from the intensity of affect. Cutting ends the depersonalization through color shock, pain or some other mechanism. Marks or scars from cutting may also help to combat the disorienting effects of episodes of depersonalization.

Bou **Boundaries:** cutting is a way to create boundaries or identity. Intense affect results in fear of being engulfed or fear of loss of identity. Cutting creates clear boundaries between self and other and contributes to a sense of self.

-next page-

B = Behavioral: cutting results from reinforcement
Sys = Systemic: cutting is an expression of systemic conflict
Sui = Suicide: cutting is a suicide attempt or replacement
Sex = Sexual: cutting results from conflicts re: sexuality/menarche
Exp = Expression: cutting stems from need to express intense affect
Con = Control: cutting stems from need to control intense affect
Dep = Depersonalization: cutting ends or copes with effects of depers.
Bou = Boundaries: cutting helps create boundaries & sense of self

1. Cutting stems from an ambivalent desire to destroy the genitals in order to avoid acting on sexual feelings that are seen as threatening.

B Sys Sui *Sex*
Exp Con Dep Bou
Other

2. Cutting results in attention or status (due to endurance of pain or risk) from others; patients cut to receive this attention or regard.

B **Sys Sui Sex**
Exp Con Dep Bou
Other

3. Cutting is an expression of intense anger at abandonment, where the anger is directed inwards because the cutter feels that to direct anger outwards could destroy the other person or the relationship.

B Sys Sui Sex
Exp **Con Dep Bou**
Other

4. Intense affect is experienced as being out of control. Cutting is an attempt to control affect by channeling it into something concrete and specific.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

5. Cutting is an attempt at controlled sexual penetration as opposed to penetration imposed from outside (i.e. intercourse).

B Sys Sui *Sex*
Exp Con Dep Bou
Other

-over-

B = Behavioral: cutting results from reinforcement
Sys = Systemic: cutting is an expression of systemic conflict
Sui = Suicide: cutting is a suicide attempt or replacement
Sex = Sexual: cutting results from conflicts re: sexuality/menarche
Exp = Expression: cutting stems from need to express intense affect
Con = Control: cutting stems from need to control intense affect
Dep = Depersonalization: cutting ends or copes with effects of depers.
Bou = Boundaries: cutting helps create boundaries & sense of self

6. Cutting is an attempt to control anger of another person that is directed at the cutter. The anger from others is turned into anger at self that can be controlled and will not totally destroy the self.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

7. Cutting expresses the anger and conflict of the family or environment that is not expressed in a more direct manner.

B *Sys* Sui Sex
Exp Con Dep Bou
Other

8. Perceived abandonment leads to excessive affect which leads to depersonalization. Cutting is a way to end depersonalization through color shock, pain or some other mechanism.

B Sys Sui Sex
Exp Con *Dep* Bou
Other

9. Cutting establishes clear boundaries between self and other by reaffirming the basic boundary of the flesh.

B Sys Sui Sex
Exp Con Dep *Bou*
Other

10. Patients observe that other cutters achieve relief from emotional pain. They imitate this behavior and continue it when they achieve the same relief.

B **Sys Sui Sex**
Exp Con Dep Bou
Other

-next page-

B = Behavioral: cutting results from reinforcement
Sys = Systemic: cutting is an expression of systemic conflict
Sui = Suicide: cutting is a suicide attempt or replacement
Sex = Sexual: cutting results from conflicts re: sexuality/menarche
Exp = Expression: cutting stems from need to express intense affect
Con = Control: cutting stems from need to control intense affect
Dep = Depersonalization: cutting ends or copes with effects of depers.
Bou = Boundaries: cutting helps create boundaries & sense of self

11. Cutting is a suicide replacement where death is avoided by replacing it with partial destruction.

B Sys *Sui* Sex
Exp Con Dep Bou
Other

12. Cutting is an expression of affect that is experienced as so intense the patient feels it cannot be contained.

B Sys Sui Sex
Exp **Con Dep Bou**
Other

13. Cutting is a result of a negative reaction to menarche where bleeding is exposed and controlled rather than hidden and involuntary.

B Sys Sui *Sex*
Exp Con Dep Bou
Other

14. Cutting is punishment for sexual feelings.

B Sys Sui *Sex*
Exp Con Dep Bou
Other

15. Cutting creates a feeling of control as the cutter feels that she controls her own life and death.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

16. Cutting establishes clear boundaries between self and other by creating something that is uniquely "mine," i.e. blood.

B Sys Sui Sex
Exp Con Dep *Bou*
Other

-over-

B = Behavioral: cutting results from reinforcement
Sys = Systemic: cutting is an expression of systemic conflict
Sui = Suicide: cutting is a suicide attempt or replacement
Sex = Sexual: cutting results from conflicts re: sexuality/menarche
Exp = Expression: cutting stems from need to express intense affect
Con = Control: cutting stems from need to control intense affect
Dep = Depersonalization: cutting ends or copes with effects of depers.
Bou = Boundaries: cutting helps create boundaries & sense of self

17. The cutter cuts to focus attention on herself and deflect attention from other problems in the system (e.g. parental conflict).

B *Sys* Sui Sex
Exp Con Dep Bou
Other

18. Cutting is an expression of overwhelming anger and need that is seen as invalid, cutting translates the feeling into an external injury which validates and expresses the emotion.

B Sys Sui Sex
Exp **Con Dep Bou**
Other

19. Cutting is punishment for being out of control. Intense affect or needs are seen as out of control and perceived as potentially destructive.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

20. Cutting is a way to assure existence during or connect periods of depersonalization. Marks or scars from cutting are concrete evidence of existence during depersonalization.

B Sys Sui Sex
Exp Con *Dep* Bou
Other

21. Cutting establishes clear boundaries between self and other by emphasizing the personal ability to die.

B Sys Sui Sex
Exp Con Dep *Bou*
Other

-next page-

B = Behavioral: cutting results from reinforcement
Sys = Systemic: cutting is an expression of systemic conflict
Sui = Suicide: cutting is a suicide attempt or replacement
Sex = Sexual: cutting results from conflicts re: sexuality/menarche
Exp = Expression: cutting stems from need to express intense affect
Con = Control: cutting stems from need to control intense affect
Dep = Depersonalization: cutting ends or copes with effects of depers.
Bou = Boundaries: cutting helps create boundaries & sense of self

22. Cutting is an attempt to actively control others: "if you leave, I will hurt myself."

B **Sys Sui Sex**
Exp Con Dep Bou
Other

23. Cutting is a way to control feelings of abandonment; cutting helps the patient withdraw from others before others can withdraw from the cutter.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

24. Cutting and blood prove independent existence; it is a solitary act with concrete consequences and proof of own will.

B Sys Sui Sex
Exp Con Dep *Bou*
Other

25. Early family experiences link pain and care through physical abuse and forgiveness cycle. Cutting is an attempt to reenact this cycle and produce caring by producing pain.

B **Sys Sui Sex**
Exp Con Dep Bou
Other

26. Cutting is a masturbation equivalent, offering sexual gratification.

B Sys Sui *Sex*
Exp Con Dep Bou
Other

27. Cutting is an attempt to control the intensity of affect by turning it into something external that can be distanced from.

B Sys Sui Sex
Exp *Con* Dep Bou
Other

28. Cutting creates a definite identity: "I bleed therefore I am" or "I am a cutter."

B Sys Sui Sex
Exp Con Dep *Bou*
Other

APPENDIX D

SURVEY COVER LETTER

John Doe, Ph.D.
Any Street
Anytown, Anystate, 00000

January 7, 1993

Dear Dr. Doe,

I am a doctoral student at the University of Massachusetts at Amherst, doing my dissertation work on self-mutilating behavior in outpatient adolescents. The literature suggests that there are a variety of reasons for engaging in the "delicate self-cutting syndrome," where patients repeatedly make multiple, non-lethal cuts or scratches. I am interested in whether the various conceptualizations offered in the literature coincide with the experience of therapists treating these patients.

You are one of a small group chosen from the *National Register of Health Service Providers in Psychology.* If you have treated or are treating in individual therapy, a female patient aged 13 to 25 who engaged in delicate self-cutting as defined above, I would greatly appreciate it if you would take approximately 30 minutes and complete both this questionnaire and the enclosed response postcard. Your participation will ensure that my results are meaningful for evaluating whether the available theories regarding this behavior are helpful to practitioners. If you have not seen one of these patients, or choose not to participate in this study, please return only the enclosed response postcard. Whether or not you choose to participate, if you would like to receive a summary of the results, please check the appropriate space on the response postcard.

All of your responses will remain confidential; the survey is completely de-identified and cannot be paired with the numbered postcards. The purpose of the numbered postcard is to allow me to identify who has not responded at all so that I may send follow-up mailings selectively. If you have any questions feel free to leave a message for me at (phone number) and I will return your call as promptly as possible. Your assistance is greatly appreciated.

Sincerely,

Karen L. Suyemoto, M.S.
Doctoral Candidate
University of Massachusetts

Marian L. MacDonald, Ph.D.
Professor of Psychology
University of Massachusetts

APPENDIX E

SURVEY

DELICATE SELF-CUTTING IN FEMALE ADOLESCENTS

INSTRUCTIONS

This survey is designed to gather information about delicate self-cutting. If you have ever seen a **female adolescent (13-25) who engaged in delicate self-cutting** (defined as more than one instance of non-lethal cutting or scratching) in **individual, outpatient therapy for at least five sessions,** please continue. If you have never seen a patient who fits this description, please fill out and mail only the Response Card.

If you are currently seeing one or more patients who fits the above description, please refer to the patient whose last name is alphabetically closest to the letter A; think about this particular young woman and answer each question with reference to her.

If you are not currently seeing a patient who fits the above description, but you have seen one or more patients who fits this description in the past, please refer to the most recently terminated individual; think about this particular young woman and answer each question with reference to her.

In order to maintain anonymity, please do not put your name on this questionnaire. Please note that the questionnaire is two-sided. Thank you very much for your time and assistance in this project.

-next page-

The following questions concern delicate self-cutting:

Research indicates that there are some issues--such as low self-esteem, poor coping skills and difficulty with anger and self-soothing--that are common to the majority of patients who engage in delicate self-cutting. Research also indicates that the most common precipitant to a self-cutting incident is the perception of abandonment by a significant other which leads to intense feelings of anger, anxiety or loss. However, there is less agreement on the more detailed reasons behind delicate self-cutting. While focusing on your referent patient, please rate each of the following possible reasons for cutting from 1 (not at all a reason for this person's cutting) to 6 (one of the major reasons this person engaged in cutting).

Her cutting stems from an ambivalent desire to destroy the genitals in order to avoid acting on sexual feelings that are seen as threatening. **1 2 3 4 5 6**

Her cutting results in attention or status (due to endurance of pain or risk) from others; she cuts to receive this attention or regard. **1 2 3 4 5 6**

Her cutting is an expression of intense anger at abandonment, where the anger is redirected inwards because she feels that to direct anger outwards could destroy the other person or the relationship. **1 2 3 4 5 6**

She experiences her intense affect as being out of control. Her cutting is an attempt to control her affect by channeling it into something concrete and specific. **1 2 3 4 5 6**

Her cutting is an attempt at controlled sexual penetration as opposed to penetration imposed from outside (i.e. intercourse). **1 2 3 4 5 6**

-over-

(Cont.: 1 = not at all a reason for this person's cutting; 6 = one of the major reasons this person engaged in cutting).

Her cutting expresses the anger and conflict of the family or environment that is not expressed in a more direct manner.	1	2	3	4	5	6
Perceived abandonment leads to excessive affect which leads to depersonalization. Her cutting is a way to end depersonalization through color shock, pain or some other mechanism.	1	2	3	4	5	6
Her cutting establishes clear boundaries between self and other by reaffirming the basic boundary of the flesh.	1	2	3	4	5	6
She observed that other cutters achieve relief from emotional pain. She imitated this behavior and continued it when she achieved the same relief.	1	2	3	4	5	6
Her cutting is a suicide replacement where death is avoided by replacing it with partial destruction.	1	2	3	4	5	6
Her cutting is punishment for sexual feelings.	1	2	3	4	5	6
Her cutting is an expression of overwhelming affect that is experienced as so intense she feels it cannot be contained.	1	2	3	4	5	6
Her cutting is a result of a negative reaction to menarche where bleeding is exposed and controlled rather than hidden and involuntary.	1	2	3	4	5	6
Her cutting creates a feeling of control as she feels that she controls her own life and death.	1	2	3	4	5	6

-next page-

(Cont.: 1 = not at all a reason for this person's cutting; 6 = one of the major reasons this person engaged in cutting).

Her cutting establishes clear boundaries between self and other by creating something that is uniquely "mine," i.e. blood.	1	2	3	4	5	6
She cuts to focus attention on herself and deflect attention from other problems in the system (e.g. parental conflict).	1	2	3	4	5	6
Her cutting is an expression of overwhelming anger and need that is seen as invalid, cutting translates the feeling into an external injury which validates and expresses the emotion.	1	2	3	4	5	6
Her cutting is punishment for being out of control. She sees intense affect or needs as out of control and potentially destructive.	1	2	3	4	5	6
Her cutting is a way to assure existence during or connect periods of depersonalization. Marks or scars from cutting are concrete evidence of her existence during depersonalization.	1	2	3	4	5	6
Her cutting establishes clear boundaries between self and other by emphasizing the personal ability to die.	1	2	3	4	5	6
Her cutting is a masturbation equivalent, offering sexual gratification.	1	2	3	4	5	6
Her cutting creates a definite identity: "I bleed therefore I am" or "I am a cutter."	1	2	3	4	5	6

-over-

To what extent did your understanding of the reasons behind the cutting behavior affect your treatment of this person(1 = did not affect treatment at all; 6 = significantly affected treatment)? **1 2 3 4 5 6**

If you have seen more than one self-cutting patient, to what extent are their reasons for cutting the same as those you have endorsed for your referent patient (1 = not at all the same; 6 = practically identical)? **1 2 3 4 5 6**

Approximately how old was this person at the time of the first cutting incident? _____ **years**

Approximately how many instances of cutting did this patient engage in?
_____ **1-4**
_____ **5-14**
_____ **15+**

Approximately what period of time (in months and years) did the instances of cutting span?
_____ **months**
_____ **years**

If this person stopped cutting, approximately how old was this person at the time of the last cutting incident? _____ **years**

Was this person's delicate self-cutting behavior related to an attempt at suicide (1 = no, she was definitely not attempting suicide; 6 = yes, she was attempting suicide)? **1 2 3 4 5 6**

-next page-

To what extent do you connect cutting to this individual's struggle with the following developmental issues. Please rate each issue on a scale from 1 = not at all to 8 = very much

Establishing identity	1	2	3	4	5	6
Establishing independence & self-motivation	1	2	3	4	5	6
Separating from parents	1	2	3	4	5	6
Dealing with the physical changes of puberty	1	2	3	4	5	6
Resolution of aggressive feelings toward mother	1	2	3	4	5	6
Resolution of sexual feelings toward father	1	2	3	4	5	6
Differentiation from mother	1	2	3	4	5	6
Achieving internal ability to soothe & forgive	1	2	3	4	5	6
Achieving an internal sense of self acceptance	1	2	3	4	5	6
Achieving a sense that others will continue to care over time, even if separated or angry	1	2	3	4	5	6
Achieving a sense of self consistent across situations	1	2	3	4	5	6
Achieving ability to use symbols to express oneself, including the use of abstract language	1	2	3	4	5	6
Resolving the sense that one is responsible for all occurrences and others' emotions	1	2	3	4	5	6
Achieving an internal conscience that is realistic and has the capacity to forgive	1	2	3	4	5	6
Achieving a sense of something to strive toward in terms of self, i.e. an internal ideal	1	2	3	4	5	6
Integrating bad & good within the self and others	1	2	3	4	5	6
Achieving a clear sense of what is self and what is not, including ability to distance from others' emotions	1	2	3	4	5	6
Resolving desire to become a part of another	1	2	3	4	5	6

-over-

The following questions concern this person's diagnosis and therapy history:

What Axis I diagnosis did you assign to this patient?

Anorexia nervosa..... _____
Bulimia nervosa..... _____
Psychoactive substance abuse disorder..... _____
Bipolar disorder..... _____
Cyclothymia..... _____
Major depression..... _____
Dysthymia..... _____
Generalized anxiety disorder..... _____
Obsessive compulsive disorder..... _____
Multiple personality disorder..... _____
Factitious disorder..... _____
Trichotillomania..... _____
Sexual masochism..... _____
Adjustment disorder..... _____
None ..... _____

(If no Axis I diagnosis was assigned please also check the diagnosis you would assign if a diagnosis was required)

Other (please specify)_____

What Axis II diagnosis did you assign to this person?

Paranoid..... _____
Schizoid..... _____
Schizotypal..... _____
Antisocial..... _____
Borderline..... _____
Histrionic..... _____
Narcissistic..... _____
Avoidant..... _____
Dependent..... _____
Obsessive compulsive..... _____
Passive aggressive..... _____
None ..... _____

(If no Axis II diagnosis was assigned, please also check the personality style that you feel best fits this patient)

Other (please specify)_____

-next page-

Was the cutting behavior the primary determinant of your diagnosis (1 = no, other symptom(s) were the primary determinant(s); 6= yes, cutting was the primary determinant)? **1 2 3 4 5 6**

Had this person ever been psychiatrically hospitalized prior to treatment with you? **yes no**

Had this person ever been in out-patient treatment before seeing you? **yes no**

If yes, what type of treatment:

Individual therapy _____

Family therapy _____

Group therapy _____

Other (please describe)_____

Please rate this patient on each of the following summary statements of the reasons for cutting from 1 (does not apply to this person at all) to 6 (applies to this person very well, this is the major dynamic behind the cutting behavior)

Her cutting primarily relates to conflicts about sexuality and menarche. Her cutting serves to punish the body for sexual feelings or create feelings of sexual excitement. **1 2 3 4 5 6**

Her cutting is related primarily to the need for control. Cutting serves to control and distance from overwhelming emotions, as well as punish the self for feelings or needs that seem excessive and out of control. **1 2 3 4 5 6**

Her cutting primarily relates to an unconscious desire for suicide. It is a suicide replacement destroying only part of the body or self. **1 2 3 4 5 6**

-over-

(Cont.: 1 = does not apply to this person at all; 6 = applies to this person very well, this is the major dynamic behind the cutting behavior.)

Her cutting is a way to end depersonalization which itself is a reaction to excessive emotion. Her cutting also helps cope with the disorienting effects of depersonalization by providing concrete proof of existence. **1 2 3 4 5 6**

Her cutting is related primarily to the need to create boundaries between self and other or to create a clear sense of identity. Intense feelings of anger or need threaten her sense of self and cutting helps restore it. **1 2 3 4 5 6**

Her cutting primarily relates to the need to protect the family by expressing the difficult conflicts and feelings that others are denying or not expressing and by keeping the focus on the cutting behavior. **1 2 3 4 5 6**

Her cutting is related primarily to the need to express or internalize overwhelming affect. Control is not as much an issue as the need for expression and the feeling that affect is too intense to be contained without destruction. **1 2 3 4 5 6**

Her cutting began as a linking of injury and care and continues primarily due to obtaining the rewards of relief of negative emotions, attention and social status. **1 2 3 4 5 6**

The following questions concern the patient's therapy experience:

How old was this person when they began therapy with you? _____ **years**

-next page-

How long was this person in treatment with you approximately how many months and sessions)? _____ **months** _____ **sessions**

Was this person psychiatrically hospitalized during treatment with you? **yes** **no**

Was this person receiving additional treatment while seeing you? **yes** **no**

If yes, what type of treatment

Individual therapy _____

Family therapy _____

Group therapy _____

Other (please describe)_____

How long ago was this patient seen? _____ **years**

How long had you been practicing when you first saw this patient? _____ **years**

Was this person receiving psychotropic medication during treatment with you? **yes** **no**

If yes, what type

Antidepressants..... _____

Antipsychotics..... _____

Minor tranquilizers..... _____

Antianxiety medication..... _____

To what extent did you directly address the cutting behavior in therapy (1 = not at all, never discussed it; 6 = significantly, a major focus was the behavior and the underlying issues)? **1 2 3 4 5 6**

Did therapy contribute to this patient stopping or decreasing cutting? **yes** **no**

-over-

Research suggests that there are some factors, such as an increase in self-esteem, an improved ability to cope with affect and the experience of an accepting relationship, that are common to the vast majority of effective therapies with self-cutting patients. However, there is less agreement on more detailed reasons why patients stop cutting. While focusing on your referent patient, please rate each of the following 8 possible reasons for stopping cutting from 1 (not at all a reason for this person) to 6 (one of the major reasons this person stopped cutting behavior).

Her cutting stopped or decreased due to changes in the rewards she could get from others by cutting. She learned other ways to obtain attention, social status and relief from negative emotions. **1 2 3 4 5 6**

Her cutting stopped or decreased due to learning other ways to control her emotions or interactions with others and learning that intense emotions cannot destroy her. **1 2 3 4 5 6**

Her cutting stopped or decreased due to changes in the family or this patient's relationship to it: conflict was expressed more directly or by other members or she learned to better distance herself from family conflict. **1 2 3 4 5 6**

Her cutting stopped or decreased due to resolution of suicidal feelings and wishes. **1 2 3 4 5 6**

Her cutting stopped or decreased due to a greater acceptance of her own needs and emotions and learning to express her feelings verbally or through other less destructive means. **1 2 3 4 5 6**

Her cutting stopped or decreased due to a decrease in episodes of depersonalization as she learned to cope with intense affect. **1 2 3 4 5 6**

-next page-

(Cont.: 1 = not at all a reason for this person; 6 = one of the major reasons this person stopped cutting behavior.)

Her cutting stopped or decreased due to resolution of negative or ambivalent feelings about sexuality and menarche. **1 2 3 4 5 6**

Her cutting stopped or decreased due to the development of clearer boundaries and learning alternative ways to affirm her sense of self. **1 2 3 4 5 6**

Please rate the overall success of the therapy from 1 (not at all successful) to 6 (very successful). **1 2 3 4 5 6**

The following questions concern you and your approach and experience as a therapist:

Are you : **male female**

What degree do you hold? **MSW PhD PsyD EdD**

What is your theoretical orientation?

psychoanalytic..... _____
psychodynamic..... _____
client-centered/Rogerian..... _____
object relations..... _____
self psychology..... _____
ego psychology..... _____
existential..... _____
gestalt..... _____
other (please specify)_____
cognitive-behavioral..... _____
behavioral..... _____
systemic..... _____
eclectic ..... _____
(if you choose this option, please check which one of the above best fits the foundation of your eclectic views)
other (please specify)_____

-over-

In what setting was this patient seen

Private practice..... _____
Clinic..... _____
Outpatient program of hospital..... _____
Community mental health center..... _____
Other (please specify)_____

OTHER

In the space below, please add any comments you wish that would clarify your answers above (please refer to questions by number) or any additional comments that you feel would be helpful in understanding this patient, and your understanding of the self-mutilating behavior:

Thank you for taking the time to complete this survey. Your participation is greatly appreciated.

APPENDIX F

RESPONSE POSTCARD

Subject #XX

I completed the survey and mailed it separately. _____

I did not complete the survey for the following reason:

I have never seen a patient who engaged in delicate self-cutting _____

I have seen a delicate self cutter but he/she did not fit your other criteria _____

I have seen a patient who fit your criteria, but chose not to complete your survey _____

Other (please specify)_____

I would like a summary of your results _____

Thank you for your participation.

APPENDIX G

FOLLOW-UP POSTCARD

Date

Dear Colleague,

Recently I requested your assistance in my dissertation research by asking you to complete a survey focusing on the symptom of self-mutilation or "delicate self-cutting" in female adolescents. As you may recall, I am investigating whether our theoretical understanding of this behavior is congruent with the conceptualization of therapists who are actually treating these patients. If you have recently completed the survey and/or response postcard, thank you very much. If you have not, I would greatly appreciate it if you would reconsider your decision to participate and fill in the response card and complete the survey if it is appropriate. I am grateful for your participation.

Sincerely,

Karen L. Suyemoto
University of Massachusetts

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